Statement of Certifying Physician for Therapeutic Footwear

Patient Name: _____

Address: _____

Phone: _____

I certify that all of the following are true:

1. This patient has diabetes mellitus ICD-9 Code:_____ (250.00-250.93)
2. This patient has one or more of the following conditions *(Check all that apply):*

- ❑ History of partial or complete amputation of the foot
- ❑ Peripheral neuropathy with evidence of **callus formation**
- ❑ History of previous foot ulceration
- ❑ Foot deformity (Bunion, Hammertoe, etc.)
- ❑ History of pre-ulcerative callus
- ❑ Poor circulation

3. I am treating this patient under a comprehensive plan of care for his/her diabetes.
4. This patient needs special shoes (depth or custom-molded shoes) and inserts.
5. Patient is taking the following medication:

_____

_____

Certifying Physician Information

Doctor Name: _____

Address: _____

Phone: _____

Signature: _____

Date: _____

NPI # _____

**This form should be filled out by the physician managing the patient's diabetes, and faxed to The Sole Authority or the patient can bring it to their appointment.*

THE SOLE AUTHORITY

954-597-7060

954-721-3772 FAX

8307 N. Pine Island Road • Tamarac, FL 33321

info@thesoleauthority.com

WWW.THESOLEAUTHORITY.COM

The Sole Authority

✔ The Sole Authority must receive this statement from the physician actively treating you for diabetes. Please have it filled out and bring it to your appointment with The Sole Authority.

✔ We will always use the highest standards of quality and workmanship.

✔ We will always take the necessary time to measure your foot with the Branick device to ensure a precise shoe fit.

✔ Unlike most of our competitors, we take a direct contact impression of your foot... Guaranteeing the mold will be your exact fit. No digital or foam impressions which could lead us to a larger margin of error than direct contact impressions.

"Quality care and satisfaction is our priority."