PHYSICIAN'S ORDER FOR DIABETIC SHOES AND INSOLES

COLONIAL MEDICAL SUPPLIES ALT
614 E ALTAMONTE DR
ALTAMONTE SPRGS, FL 32701
(407)849-6455 **Fax: (407)849-6458**

Effective Date / /

Patient Information	**Physician Information**
,	,
DOB: / /	**Fax:** NPI:

All sections must be completed. Please initial and date any changes you make to this information.

DIAGNOSIS INFORMATION

___ Non Insulin Dependent	250.00
___ Insulin Dependent	250.01
___ Diabetic Circulation	250.70
___ Neuropathy	337.1
___ Defective Circulation	459.89
___ Ankle Pain & Support	719.47
___ Disuse Atrophy	728.2
___ Other (specify code)	__ __ __. __ __

Shoes and Insoles Length of Need: 12 months unless otherwise specified: _____

Prognosis: **___Good** **___Fair** **___Poor**

Wt. _____lbs. **Ht._____in.**

Ordering an Ankle Gauntlet (L1902)? **____ Yes** **____ No**

Ankle Gauntlet Length of Need: 9 months unless otherwise specified

QUALIFYING CRITERIA (Attending physician MUST answer ALL of the following):

1. Does the patient have one or more of the following conditions:

a. Previous amputation of the other foot or part of either foot?	____ Yes	____ No
b. History of previous foot ulceration of either foot?	____ Yes	____ No
c. History of pre-ulcerative calluses of either foot?	____ Yes	____ No
d. Peripheral neuropathy with evidence of callus formation of either foot?	____ Yes	____ No
e. Foot deformity of either foot?	____ Yes	____ No
f. Poor circulation in either foot?	____ Yes	____ No

2. Does the following statement define the patient's situation:
The patient is under a comprehensive plan of care for their diabetes and needs diabetic shoes.
____ Yes ____ No

3. I am treating this patient under a comprehensive plan of care for his/her diabetes. ____ Yes ____ No

4. This patient needs special shoes (depth or custom-molded shoes) because of his/her diabetes.
____ Yes ____ No

Physician please note: No product authorized herein will be supplied without the consent of the patient.

BY SIGNING BELOW, I AM STATING THAT: I am or was this patient's treating physician during the order period. This order accurately reflects the patient's condition, my prescription for treating their foot/ankle condition(s), and is substatiated by medical records **I will maintain an original signed copy of this order in my medical records and make it available to Medicare, their authorized agents or other insurer, if required.**

X _____ **Date** _____ **NPI #** _____

Physician Signature