

Physicians/Patients

Diabetic Shoe Requirements Per Insurance:

1. **Foot Exam:** Notes from f2f visit documenting a detailed foot exam with **(One or more of the required foot conditions)**. Prescribing Physician **within the last 3 months**.

NEED A COPY OF FOOT EXAM!

2. **Dispensing Order (Rx):** Prescribing Physician.

3. **Standard Written Order (SWO):** Prescribing Physician.

4. **Diabetic Exam:** Notes from **f2f diabetic exam** with **(MD or DO)** within the last **3 months** documenting **(Glucose levels, A1C results and Diabetic medications)**. ***NP/PA's*** the diabetic exam must be done by an **MD or DO**. Diabetic notes cannot be done by NP/PA (If the patient sees a NP or PA normally, they will need to make an appointment specifically for their diabetes with the MD or DO that oversees them.)

NEED A COPY OF DIABETIC EXAM!

5. **Certifying Statement:** Must be completed by the **(MD or DO)** providing the diabetic exam.

We know these requirements place a burden on everyone, but we will need all the required documents before we can proceed. Once all paperwork is completed you may fax, mail, email or bring in person to our office so that one of our staff members can review before we schedule for measurements. Please contact us if you need any additional information or may have any questions.

Annual Comprehensive Diabetes Foot Exam Form

Name: _____ Date: _____ ID#: _____

- I. Presence of Diabetes Complications**
 1. Check all that apply.
 Peripheral Neuropathy
 Nephropathy
 Retinopathy
 Peripheral Vascular Disease
 Cardiovascular Disease
 Amputation (Specify date, side, and level)

2. Any change in the foot since the last evaluation? Y ___ N ___
 3. Any shoe problems? Y ___ N ___
 4. Any blood or discharge on socks or hose? Y ___ N ___
 5. Smoking history? Y ___ N ___
 6. Most recent hemoglobin A1c result _____% _____ date

Measure, draw in, and label the patient's skin condition, using the key and the foot diagram below.
 C=Callus U=Ulcer PU=Pre-Ulcer
 F=Fissure M=Maceration R=Redness
 S=Swelling W=Warmth D=Dryness

- 2. Note Musculoskeletal Deformities**
 Toe deformities
 Bunions (Hallus Valgus)
 Charcot foot
 Foot drop
 Prominent Metatarsal Heads

Current ulcer or history of a foot ulcer?
 Y ___ N ___

- III. Foot Exam**
1. Skin, Hair, and Nail Condition
 Is the skin thin, fragile, shiny and hairless? Y ___ N ___
 Are the nails thick, too long, ingrown, or infected with fungal disease? Y ___ N ___

- 3. Pedal Pulses** Fill in the blanks with a "P" or an "A" to indicate present or absent.
 Posterior tibial Left ___ Right ___
 Dorsalis pedis Left ___ Right ___

For Sections II & III, fill in the blanks with "Y" or "N" or with an "R," "L," or "B" for positive findings on the right, left, or both feet.

- II. Current History**
 1. Is there pain in the calf muscles when walking that is relieved by rest?
 Y ___ N ___

4. Sensory Foot Exam Label sensory level with a "+" in the five circled areas of the foot if the patient can feel the 5.07 (10-gram) Semmes-Weinstein nylon monofilament and "-" if the patient cannot feel the filament.

Notes



Right Foot

Notes



Left Foot

IV. Risk Categorization Check appropriate box.

- | | |
|---|--|
| <input type="checkbox"/> Low Risk Patient
All of the following: | <input type="checkbox"/> High Risk Patient
One or more of the following: |
| <input type="checkbox"/> Intact protective sensation | <input type="checkbox"/> Loss of protective sensation |
| <input type="checkbox"/> Pedal pulses present | <input type="checkbox"/> Absent pedal pulses |
| <input type="checkbox"/> No deformity | <input type="checkbox"/> Foot deformity |
| <input type="checkbox"/> No prior foot ulcer | <input type="checkbox"/> History of foot ulcer |
| <input type="checkbox"/> No amputation | <input type="checkbox"/> Prior amputation |

V. Footwear Assessment Indicate yes or no.

1. Does the patient wear appropriate shoes? Y ___ N ___
 2. Does the patient need inserts? Y ___ N ___
 3. Should corrective footwear be prescribed? Y ___ N ___

VI. Education Indicate yes or no.

1. Has the patient had prior foot care education? Y ___ N ___
 2. Can the patient demonstrate appropriate foot care? Y ___ N ___
 3. Does the patient need smoking cessation counseling?
 Y ___ N ___
 4. Does the patient need education about HbA1c or other diabetes self-care? Y ___ N ___

VII. Management Plan Check all that apply.

- 1. Self-management education:**
 Provide patient education for preventive foot care. Date: _____
 Provide or refer for smoking cessation counseling. Date: _____
 Provide patient education about HbA1c or other aspect of self-care. Date: _____
- 2. Diagnostic studies:**
 Vascular Laboratory
 Hemoglobin A1c (at least twice per year)
 Other: _____
- 3. Footwear recommendations:**
 None
 Athletic shoes
 Accommodative inserts
 Depth shoes
- 4. Refer to:**
 Primary Care Provider
 Diabetes Educator
 Podiatrist
 RN Foot Specialist
 Pedorthist
 Orthotist
 Endocrinologist
 Vascular Surgeon
 Foot Surgeon
 Rehab. Specialist
 Other: _____
- 5. Follow-up Care:**
 Schedule follow-up visit. Date: _____

Provider Signature _____



LeTourneau
PROSTHETICS®

A New Beginning

Beaumont, Texas
2452 Calder Ave.
Beaumont, TX 77702
409-832-5005
409-832-5015/Fax
409-434-1821/Fax

Nederland, Texas
1431 South Hwy. 69
(Behind Schooner)
Nederland, TX 77627
409-722-2163
409-832-5015/Fax

Jasper, Texas
2051 S. Wheeler,
Ste. D
Jasper, TX 75951
409-384-9306
409-832-5015/Fax

SERVICES

- Prosthetics
- Myoelectric Specialists
- Spinal Bracing
- Diabetic Shoes
- Pediatrics
- Upper/Lower Extremity Bracing

DATE

PATIENTS NAME



STATEMENT OF MEDICAL NECESSITY

A. Diagnosis: _____

B. ICD-10 Code: _____

Physician's Name: _____
(PLEASE PRINT)

Physician's Address: _____

Phone #: _____

I certify that the above items are medically necessary for the treatment of the patient for the above condition.

NPI #

Physician's Signature
(Stamps Invalid)

M.D.

STANDARD WRITTEN ORDER

Patient:	DOB:	Date of Order:
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NAME

ADDRESS

CITY, STATE, ZIP

QTY	CODE	DESCRIPTION
1	A5500	Diab shoe for density insert
1	A5500	Diab shoe for density insert
3	A5512	Multi den insert direct form
3	A5512	Multi den insert direct form

X Physician Signature _____

Physicians Name:

_____ Date

Address:

Phone:

Fax:

NPI #:

STANDARD WRITTEN ORDER

Patient:	DOB:	Date of Order:
-----------------	-------------	-----------------------

NAME

ADDRESS

CITY, STATE, ZIP

QTY	CODE	DESCRIPTION
1	A5500	Diab shoe for density insert
1	A5500	Diab shoe for density insert
3	A5514	Multi den insert direct carv/cam
3	A5514	Multi den insert direct carv/cam

X Physician Signature _____

Physicians Name:

_____ Date

Address:

Phone:

Fax:

NPI #:

STANDARD WRITTEN ORDER

Patient:	DOB:	Date of Order:
-----------------	-------------	-----------------------

NAME

ADDRESS

CITY, STATE, ZIP

QTY	CODE	DESCRIPTION
1	A5500	Diab shoe for density insert
1	A5500	Diab shoe for density insert
3	A5514	Multi den insert direct carv/cam
3	A5514	Multi den insert direct carv/cam

X Physician Signature _____

Physicians Name:

_____ Date

Address:

Phone:

Fax:

NPI #:

LeTourneau Lifelike Orthotics & Prosthetics, Inc.

Statement of Certifying Physician for Therapeutic Footwear

**** Certifying Physician must be the MD or DO managing the patient's diabetic condition****

Patient Name: _____ DOB #: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

I certify that all of the following statements are true:

1) This patient has diabetes mellitus (ICD-10 Code): _____ (E08.00-E13.9)

2) This Patient has one or more of the following conditions (**Check all that apply**):

- History of partial or complete foot amputation
- History of pre-ulcerative callous
- Peripheral neuropathy with callous formation ****Both must be documented****
- Foot deformity
- Poor Circulation (i.e. diagnosis of venous / arterial insufficiency and symptoms, signs test documenting **in detail** one of these diagnoses.)
- Previous ulcer(s)

Patient was last seen within the <u>last 6 months</u> in my office on: Date: _____ _____
--

3) I am treating this patient under a comprehensive plan of care for his/her diabetes.

4) This patient needs special shoes and/or inserts because of their diabetic condition.

Certifying Physician(MD/DO) information:

Name (Printed): _____ NPI #: _____

Address: _____

City: _____ State: _____

Zip: _____ Phone: _____

By signing this form, I agree that I have performed an in person evaluation of this patient within the last 6 months, and there is documentation in the patient's medical records indicating my management of the patient's diabetes, and that documentation of one or more of the conditions listed under item #2 is present in those records.

Signed: _____ Todays Date: _____