Ortho Engineering Inc.

Orthotics | Prosthetics | Therapeutic Shoes

Prescription Form for Therapeutic Footwear
(Prescribing Physician may be different from Certifying Physician)

Patient Name:_____ HIC#:_____

☑ One Pair of Extra-Depth Shoes
- OR -
☐ One Pair of Custom Molded Shoes

AND

☑ 3 Pairs of Direct Regular Formed Inserts
- OR -
☐ 3 Pairs of Custom Molded Inserts
- AND/OR -
☐ Custom Partial Foot Insert **(Left) (Right)**

Prescribing Physician Information

Signature:_____ NPI#:_____

Name:_____ Date:_____

Statement of Certifying Physician For Therapeutic Footwear
(Prescribing Physician may be different from Certifying Physician)

I certify that all of the following statements are true:

1. This patient has diabetes mellitus.
2. This patient has one or more of the following conditions. (Circle all that apply):
   a) History of partial or complete amputation of the foot
   b) History of previous foot ulceration
   c) History of pre-ulcerative callus
   d) Peripheral neuropathy with evidence of callus formation
   e) Foot deformity
   f) 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) because of his/her diabetes.

Certifying Physician Information

Signature:_____ NPI#:_____

Name (Must be MD or DO):_____ Date:_____

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