

Prescription

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| PURPOSE (desired effects): Patient objective is to transfer from high to low pressure areas, giving protection for the insensitive diabetic foot, absorb shock and reduce shearing, modify weight transfer patterns, limit motion of painful inflamed joints, facilitate ambulating and maximize comfort. |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Patient’s Name: |  | |  |  | | | |
| Patient’s Address: |  | |  |  | | | |
| City/State/Zip: |  | |  | |  | |
| Patient’s Phone: |  | **DOB:** | | | |  | |
|  |  |  | | | |  | |

DIAGNOSIS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Footwear: Please use ICD-10 codes

1. A5500 – Therapeutic Shoes – 1 pair

With: (please circle one)

1. A5512 – Heat Molded Diabetic Inserts – 3 Pair

Or

1. A5514 – Custom Molded Diabetic Inserts – 3 pair

**………………………………………………………………….**

Physician’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name (Printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_UPIN#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NPI#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_Phone (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_