PRESCRIPTION FOR PATIENTS WITH DIABETES

Patient's Name: _____ D.O.B. _____/_____/_____
Address: _____ City: _____
State: _____, Zip Code: _____, Phone: (_____)_____
Medicare Number: _____

DX:

RX:

Prescriber's Information:

Name: _____ Signature: _____

Address: _____ City: _____

State: _____, Zip Code: _____ NPI: _____

Office Number: _____ Fax Number: _____

Under the DX portion above please indicate that the patient has diabetes and any of the following which apply: Impaired Circulation, Diabetic Ulcer, Hallux Valgus, Contracted Digits, Charcot, Peripheral Neuropathy, Pre-Ulcerative Callous Formation, History of Previous Ulcerations, History of Previous Foot Amputation or part thereof, and/or any other foot condition (please identify). **PLEASE USE I C D 10 Codes also.**

Under the RX portion above please indicate the types of pedorthic modalities you are requesting for the patient. Your Choices are: Depth Inlay Shoes (A5500); Custom Molded Shoes (A5501); Multi-Density Heat Molded Inserts (A5512); Custom Molded Inserts (A5513); Rockersoles (A5503); Heel or Sole Wedge (A5504); Metatarsal Bars (A5505); Offset Heels (A5506); TMA Filler (L5000, toe filler); and Arizona AFO. Please indicate if the modality is right, left or bilateral.

Please redeem at: **Michelangelo's Foot Comfort & Pedorthic Shoppe**
www.PedorthicSolutions.com
8344 W. Lawrence Ave.
Norridge, Illinois 60706-3152
Tel. 708-453-4900; Fax 708-453-3338

Board Accredited Pedorthic Facility
Accredited by the American Board for Certification in Orthotics, Prosthetics & Pedorthics