CERTIFICATION OF MEDICAL NECESSITY FOR THERAPEUTIC SHOES

Patient Name: _____

This patient needs special shoes to prevent further deterioration of his/her foot condition as a complication of diabetes mellitus.

Risk factors: (Check all that apply)

- ☐ History of previous ulceration
- ☐ Callous formation
- ☐ Toe deformity (hammer-toe, claw-toe)
- ☐ Musculoskeletal deformity (hallux valgas)
- ☐ Poor circulation in legs/feet
- ☐ Diabetic neuropathy
- ☐ Other _____

Recommendations:

Standard good-quality orthopedic or athletic shoe

- ☑ Roomy toe box (wide, rounded)
- ☑ Wide width
- ☑ Extra depth
- ☑ Seamless, non-abrasive lining
- ☑ Adjustable closure (laces or velcro)
- ☑ Rocker sole

Preferred

- ☐ Insole cushioning
- ☐ Removable insole
- ☐ Customizable insert

Physician name (printed): _____

Address: _____

Date: _____