LIMBIONICS
prosthetics and orthotics

Phone: (919) 441-0023 **Fax: (919) 594-1175**

Patients: Please have your physician who manages your diabetes complete the following pages before your diabetic shoe evaluation in our office.

Attached:

- Physician Notes Guidelines mandated by Medicare
- Diabetic Verification Form
- Annual Foot Examination Form

Physicians: Please complete the attached pages and fax them back to us **accompanying your office notes.** Keep in mind, we will be sending a detailed prescription for your signature once our evaluation has been completed.

Diabetic Verification

Patient Name:	Patient ID:	Patient DOB:
Device Type: Bilateral Diabetic Shoes w/ Inserts	**Diagnosis Code (ICD-10)**	**Visit Date:**

The physician listed below certifies that all of the following statements are true:
(Physician must be an MD or DO)

1. **This patient has diabetes mellitus.**
2. **This patient has the following conditions (please check all that apply):**
   - ☐ History of partial or complete amputation of the foot
   - ☐ History of previous foot ulceration
   - ☐ History of pre-ulcerative callus
   - ☐ Peripheral neuropathy with evidence of callus formation
   - ☐ Foot deformity
   - ☐ 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.**
5. **I have seen this patient within the past six months.**

Physician Name:	Physician UPIN:	Physician NPI:	Insurance Info:

Physician Address:	
Physician Work Phone:	**Physician Fax:**

The above procedures and any repair and/or parts to maintain proper fit and function are appropriate for this patient, and are deemed medically necessary.

_____ _____

Physician Signature **Date**

_____

Print Name

Annual Comprehensive Diabetes Foot Exam

Name: _____ ID: _____

Date of Exam: _____

The patient above, does have diabetes Y _____ N _____

1. Presence of Diabetes Complications *(Check all that apply)*

☐ Peripheral Neuropathy	☐ Nephropathy	☐ Retinopathy	☐ Peripheral Vascular Disease	☐ Cardiovascular Disease	☐ Amputation *(Specify date, side, & level)* _____

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

For sections II & III, fill in the blanks with "Y" or "N" or with a "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 ___
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 _____

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___

2. **Note Musculoskeletal Deformities**
   - ☐ Toe Deformities
   - ☐ Bunions (Hallus Valgus)
   - ☐ Charcot Foot
   - ☐ Foot drop
   - ☐ Prominent Metatarsal Heads
3. **Pedal Pulses.** *Fill in the blanks with a "P" or an "A" to indicate present or absent.*

Posterior Tibial Left_____ Right _____

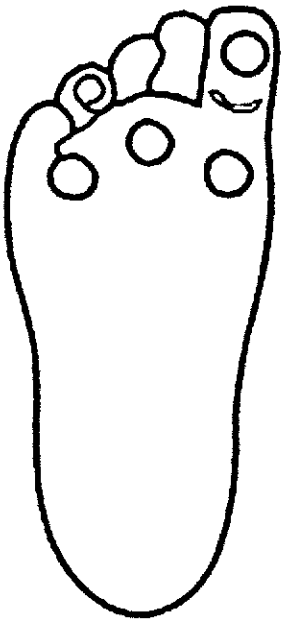
Dorsalis pedis Left_____ Right_____

Measure, draw in, and label the patient's skin condition, using the key and the foot diagram below.

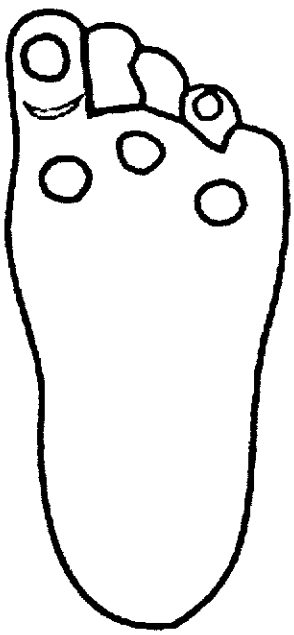
C=Callus U=Ulcer PU=Pre-Ulcer F=Fissure M=Maceration R=Redness S=Swelling W=Warmth D=Dryness

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



Left Foot

Notes:

IV. Risk Categorization *Check appropriate box*

☐ **Low Risk Patient** All of the following: ☐ Intact protective sensation ☐ Pedal pulses present ☐ No deformity ☐ No prior foot ulcer ☐ No amputation	☐ **High Risk Patient** One or more of the following: ☐ Loss of protective sensation ☐ Absent pedal pulses ☐ Foot deformity ☐ History of foot ulcer ☐ Prior amputation

V. Footwear Assessment

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

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 Hb1A1c 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:

☐ Custom shoes ☐ Depth Shoes
☐ Athletic shoes ☐ None
☐ Accommodative inserts

4. Refer to:

☐ Orthotist/Prosthetist
☐ Primary Care Provider
☐ Diabetes Educator
☐ Podiatrist
☐ RN Foot specialist
☐ Pedorthist
☐ Endocrinologist
☐ Vascular Surgeon
☐ Foot Surgeon
☐ Rehab. Specialist
☐ Other: _____

5. Follow-up Care:

Schedule follow-up visit. Date: _____

_____ _____

PHYSICIAN SIGNATURE DATE

_____

PRINTED PHYSICIAN NAME

***If the exam was performed by someone other than the Certifying Physician (MD/DO) who treats the patient for Diabetes then the Certifying Physician must review and sign the statement below:**

"I AM CERTIFYING THAT I AM THE PHYSICIAN THAT TREATS AND MANAGES THE PLAN OF CARE FOR HIS/HER DIABETES AND I HAVE REVIEWED AND AGREE WITH THE ABOVE FINDINGS."

_____ _____

CERTIFYING PHYSICIAN SIGNATURE (MD/DO) DATE

_____

PRINTED PHYSICIAN NAME