GIVE TO YOUR DOCTOR AT YOUR NEXT APPT. (MUST BE AN MD NOT A NURSE)

Vassel's

Comfort shoes and Custom Insoles!

10421 West Florissant Ave St. Louis, MO 63136

(Phone): 314-471-0059 FAX #: 314-474-0208 OR 314-471-0059

WEBSITE: VASSELS.COM

Diabetic Shoe Request

To: JAQUAN VASSEL, BOCPD **Date: _____**

Fax: _____ **Re: _____**

From: _____ **DOB: _____**

Pages (including cover sheet**): 2**

****PLEASE COMPLETE ALL STEPS!!!****

Please complete the following forms and return by mail or fax to VASSEL'S if you believe the patient should have therapeutic shoes and either heat molded or custom inserts.

STEP 1. -Complete the "Statement of Certifying Physician for Therapeutic Shoes."

STEP 2. -Complete the "Prescription."

STEP 3. *-Send a copy of the Patient's chart notes* THAT SHOW THE FOOT EXAM RESULTS AND THAT THE PATIENT IS BEING TREATED FOR DIABETES.

Thank you for your prompt attention to this matter. Please notify us if you do not believe the shoes are needed by this patient. Please notify us if the patient is no longer seeing this doctor.

Physician Certification for Therapeutic Shoes

Patient Name:	
Medicare #:	**Telephone #:**
Address:	

DOCTOR:

I certify that all of the following statements are true:

1. This patient has diabetes mellitus. Type II ___ Type I___ (**ICD-10 Code: _____**)
2. I am treating this patient under a comprehensive plan of care for his/her diabetes.
    a. Patient was last seen to discuss comprehensive plan of diabetes on _____. **(PLEASE ENTER DATE DD/MM/YYYY)**
3. This patient needs special shoes (depth or custom-molded shoes) because of diabetes.
4. This patient needs shoe inserts (heat-molded or custom fabricated) because of diabetes.
5. This patient has one or more of the following conditions:

PLEASE CIRCLE ONE OR MORE THAT APPLY (each must match medical records)

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 IN EITHER FOOT

Physician name:	
Phone #:	**NPI #:**
Address:	

Physician Signature (Must be M.D. or D.O): _____

Date: _____

Diabetic Shoe Prescription

Patient Name: _____

Address: _____

DOB: _____

Per Statement of Certifying Physician, the patient has one of more of the following foot conditions:

__Previous Amputation	__Peripheral Neuropathy w/ callus	__Previous Ulceration
__Foot Deformity	__Pre Ulcerative Callus	__Poor Circulation in the Feet

The patient requires:

__Diabetic Footwear, non-custom (A5500) - 1 pair (unless otherwise indicated)

With:

__Non custom, heat moldable inserts (A5512) -3 pairs (unless otherwise indicated)

Or

__ Custom molded inserts (A5513) -3 pairs (unless otherwise indicated

Physician Signature _____

Date: _____