J.T. *A Shoe Fitting Tradition Since 1888*
MURDOCH

623 Bloomfield Ave., Bloomfield, NJ 07003
973-748-6484 (ph) • 973-748-3466 (fax)

Statement of Certifying Physician (MD or DO) for Therapeutic Footwear

Patient Name:____ Medicare #:____________________________

I certify the following statements are true:

____ 1) This patient has Diabetes Mellitus

____ 2) This patient has one or more of the following conditions **(check all that apply)**:
____ History of partial or complete foot amputation ____ Foot deformity
____ History of pre-ulcerative callous ____ Poor circulation
____ Peripheral Neuropathy with callousing ____ Previous ulcer(s)

____ 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) with multiple density inserts because of his/her diabetes

Physician Signature:____ Date:________________________

Physician Name (printed):____

Physician Address:____

NPI#:____________________________

Prescription for Therapeutic Footwear and Inserts

(Prescribing physician may be the MD, DO or DPM and may be different from the certifying physician)

Patient Name:____ Date of Birth:_________________

Prescription: ____ 1 pair of ex-depth shoes w/ three (3) pair of heat molded multi-density inserts
____ 1 pair of ex-depth shoes w/ three pairs of custom molded inserts
____ 1 pair of custom molded shoes and custom molded inserts
____ Other (elevation, rocker soles, met bar, wedges, offsets, etc.)

Physician Signature:____ Date Signed:__________________

Physician Name:____ NPI#:________________________

Address:____