Statement Of Certifying Physician

and Prescription

Patient Name: _____ DOB: _____ Sex: Male: ☐ Female: ☐

Last First MI

Home Address: _____ Phone: _____

Medicare#: _____ Medicaid# _____ DOS: _____

Other Insurance Address Policy ID# Group#

Responsible party, if other than self:(Name, relationship, address and phone) _____

To be completed by the physician monitoring the diabetic condition

Documentation of Diabetes Mellitus must be in patients medical chart
Indicate which of the following conditions describe the patient

I certify that all of the following are true:

1 This patinet has Diabetes Mellitus ICD9 Code:

2 This patient has one of more of the following:

- ☐ History of partial or complete amputation
- ☐ 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 diabe

4 This patient needs special shoes (depth or custom-molded shoes) because of his/her diabetes

Phys. Name: _____ Phone # _____ Fax: _____ UPIN: _____

Address: _____ City/State: _____ Zip: _____

I certify that this patient has Diabetes Mellitus and is being treated under a comprehensive plan of care.

Phys. Signature: _____ Date: _____

COMPTON ORTHOPEDIC SERVICE

Oklahoma City
3703 N.W. 50th
Oklahoma City, OK 73112
Store: 405-946-3668 Fax: 405-946-3624
Office: 405-946-1016 Fax: 405-946-1650

Tulsa
6117 S. Mingo Rd. Suite F
Tulsa, OK 74133
Store: 918-294-0588 Fax: 918-294-0509