OrthoPro Services LLC

Specializing in orthopedic braces and artificial limbs

2505 Moore Station Road
Dublin, Georgia 31021
Telephone: 478.272.6522
Fax: 478.272.3992

458 Hemlock St.
Macon, GA 31201
Telephone: 478.742.0212
Fax: 478.742.0236

711 C North Jefferson Street
Albany, GA 31701
Telephone: 229.435.1409
Fax: 478-742-0236

RE: Diabetic Shoes/Insoles

Dear Physician,

In order for diabetic shoes and/or insoles to be covered by your patient's insurance we have to fulfill the three requirements listed below.

- **Initial Dispensing Order** If custom shoes and/or insoles are desired please indicated this on your order. If no details are indicated on order our orthotist will evaluate and treat based on patient's foot conditions. ____ Completed
- **Notes** from an in person visit with physician treating diabetes that also includes detailed **foot examination**. Foot Exam Form attached can be used if needed, but please make sure your notes mention exam as well. Physician notes have to be within a six month time frame before delivery of shoes; so if patient has not been seen recently they will need to come in for evaluation. ____ Completed
- **Diabetic Verification Form** which is attached. This form can be filled out by podiatrist or other medical professional but has to be signed by an MD or DO treating patient for diabetes. _____ Completed

After evaluation we will fax detailed order with letter of medical necessity for you to sign. If you have any questions or would like to speak directly to one of our orthotists please call.

Sincerely,
Administrative Staff
OrthoPro Services, LLC

DIABETES FOOT EXAM

Patient Name: _____ DOB: ___/___/_____ Date of Exam: ___/___/_____

I. Presence of Diabetes Complications
1. Check all that apply.
- ❑ Peripheral Neuropathy
- ❑ Nephropathy
- ❑ Retinopathy
- ❑ Peripheral Vascular Disease
- ❑ Cardiovascular Disease
- ❑ Amputation *(Specify date, side, and 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 an "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___

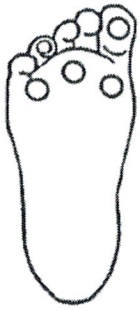
Measure, draw in, and label the patient's skin condition, using the key and the foot diagram below.
C=Callus U=Ulcer PU=Pre-Ulcer
F=Fissure M=Maceration R=Redness
S=Swelling W=Warmth D=Dryness

2. Note Musculoskeletal Deformities
- ❑ Toe deformities
- ❑ Bunions (Hallus Valgus)
- ❑ Charcot foot
- ❑ Foot drop
- ❑ Prominent Metatarsal Heads

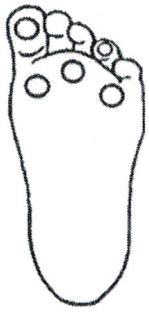
3. Pedal Pulses Fill in the blanks with a "P" or an "A" to indicate present or absent.
Posterior tibial Left_____ Right_____
Dorsalis pedis Left_____ Right_____

4. 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 *Indicate yes or no.*
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 *Indicate yes or no.*
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 HbA1c 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:
- ❑ None
- ❑ Athletic shoes
- ❑ Accommodative inserts
- ❑ Custom shoes
- ❑ Depth shoes

4. Refer to:
- ❑ Primary Care Provider
- ❑ Diabetes Educator
- ❑ Podiatrist
- ❑ RN Foot Specialist
- ❑ Pedorthist
- ❑ Orthotist
- ❑ Endocrinologist
- ❑ Vascular Surgeon
- ❑ Foot Surgeon
- ❑ Rehab. Specialist
- ❑ Other: _____

5. Follow-up Care:
Schedule follow-up visit. Date: _____

Physician Signature: _____(MD or DO) Date:_____

Printed Name:_____ Phone: _____Fax:_____

Address: _____

OrthoPro Services LLC
Specializing in orthopedic braces and artificial limbs

458 Hemlock Street
STE 100A Macon, GA 31201
Phone: 478-742-0212
Fax: 478-742-0236

2505 Moore Station Road
Dublin, GA 31021
Phone: 478-272-6522
Fax: 478-272-3992

711C N. Jefferson Street
Albany, GA 31707
Phone: 478-229-435-1409
Fax: 478-742-0236

Diabetic Verification Form

MD or DO Only

Patient Name: _____ **DOB:** _____

The physician listed below certifies that all of the following statements are true:

1) This patient has diabetes mellitus. ICD-10 Code: _____

2) This patient has the following conditions: (check all that may 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) and/or inserts because of his/her diabetic condition.

5) I have seen this patient within the past six months.

Certifying Physician Information: (must be signed by a MD or DO)

Signature: _____ **Date:** _____

Name: _____

Address: _____ **Phone:** _____

_____ **Fax:** _____

NPI #: _____

****Fax completed and signed form to
Macon/Albany 478-742-0236 Dublin 478-272-3992
OR give to patient to bring to appointment.****