OrthoPro Services LLC

Specializing in orthopedic braces and artificial limbs

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Phone: 478-272-6522
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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.****