

THE LARGEST SELECTIONS OF DIABETIC FOOTWEAR AVAILABLE!



Don't see what you want? Special Order!
Over 200 styles available for your selection!

1. Have your physician that treats your diabetes complete and sign the form below.
2. Return the completed form to the Diabetic Shoppe. (Address on back.)
3. Our Certified Pedorthist will contact you about your footwear prescription!

SOUTHERN DRUGS & DIABETIC SHOPPE

PHONE TOLL FREE 1-888-571-3533 – FAX 662-647-2411

DIABETIC SHOES & INSERTS PRESCRIPTION FORM

PATIENT ID#: _____ DATE: _____, 20 ____

PATIENT NAME: MR./MS. _____ SS#: _____

ADDRESS: _____ CITY: _____, ____ ZIP: _____

PHONE: _____ BIRTHDAY: _____

MEDICARE#: _____ MEDICAID#: _____

2ND INS.#: _____ GROUP#: _____ CARDHOLDER: _____ BDAY: _____

COMPANY: _____ ADDRESS: _____

CITY: _____, ST: _____ ZIP: _____ PHONE#: _____

Cardholder Name & B'day (If Different): _____

Diabetic Shoes (A5500) Size: _____ Multi-Density Inserts (A5512) _____

Custom-Molded Inserts (A5513) _____ Other _____ Desired Style: _____

I CERTIFY ALL OF THE FOLLOWING STATEMENTS ARE TRUE: PLEASE CHECK OR CIRCLE

This patient has Diabetes Mellitus, NIDDM or IDDM

This patient has one or more of the following conditions:

- History of partial or complete amputation of the foot (895.0 or 896.2)
- History of previous foot ulcerations (707.10)
- History of pre-ulcerative callous (700 or 707.10)
- Peripheral neuropathy with evidence of callous formation (250.60 or 443.0)
- Foot deformity (736.70)
- Poor circulation (250.70 or 443.0)

I am treating this patient under a comprehensive plan of care for his/her diabetes.

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

PHYSICIAN OR FNP NAME: _____

ADDRESS: _____ CITY: _____, ____ ZIP: _____

PHONE#: _____ FAX#: _____

UPIN#: _____ MEDICAID#: _____

Physician or FNP Signature: _____ Date: _____

DIABETIC SHOPPE PEDORTHIST PERSONALLY FITS & GUARANTEES ALL SHOES DISPENSED