VANN Healthcare

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STATEMENT OF CERTIFYING PHYSICIAN

Patient: _____

Patient D.O.B.: _____ Patient Phone: _____

1) This patient has diabetes mellitus:
☐ Type II ☐ Type I

2) **QUALIFYING CONDITIONS:** I have diagnosed and am including my notes showing that this patient has one or more of the following:
☐ Poor Circulation
☐ Foot Deformity
☐ Peripheral Neuropathy with evidence of callus formation
☐ History of Pre-ulcerative Callus
☐ History of Previous Foot Ulceration
☐ History of Partial or Complete Amputation of the Foot

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

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

5) This patient needs shoe inserts (heat molded or custom fabricated) because of his/her diabetes.

Physician Name: _____
CERTIFICATION MUST BE M.D. OR D.O.

Physician Signature: _____

NPI#: _____ Date: _____

Physician Phone: _____

Physician Address: _____

PRESCRIPTION FOR DIABETIC SHOES & INSERTS

Patient: _____

Patient D.O.B.: _____ Patient Phone: _____

1) Type of shoes prescribed (check):
☐ Extra Depth (A5500) - 1 pair, unless otherwise noted

2) Type of inserts prescribed (check one):
☐ Heat Moldable (A5512) - 3 pairs, unless otherwise noted
☐ Custom Fabricated (A5513) - 3 pairs, unless otherwise noted

ICD Notes and/or Special Instructions:

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

NOTE: SHOES, INSERTS & FOOT EXAMS CAN BE PROVIDED BY NON MD DO MEDICAL PERSONNEL.

Prescriber: _____
CERTIFICATION MUST BE M.D. OR D.O.

Prescriber Signature: _____

NPI#: _____ Date: _____

Prescriber Phone: _____

Prescriber Address: _____

Annual Comprehensive Diabetes Foot Exam Form

Name: _____ Date: _____ ID#: _____

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

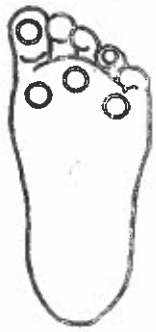
2. Note Musculoskeletal Deformities
- ☐ Toe deformities
- ☐ Bunions (Hallus Valgus)
- ☐ Charcot foot
- ☐ Foot drop
- ☐ Prominent Metatarsal Heads

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



Notes

Left Foot

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: _____

Provider Signature _____

Detach and reproduce for your practice