TruArch Foot & Brace

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TERRE HAUTE, IN 47802
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3101 N GREEN RIVER ROAD STE 730
EVANSVILLE, IN 47715
P: (812) 402-9511 F: (812) 402-0911

2801 N 6TH STREET STE A
VINCENNES, IN 47591
P: (812) 316-0316 F: (812) 316-0590

DIABETES (DM) SHOE/INSERTS CMN AND PRESCRIPTION

Patient Name: _____ DOB: _____ Phone: _____

1. This patient has Diabetes Mellitus. **Please check below which type of DM you are treating your patient for.**

DM without mention of Manifestation	☐ DX code: _____	**DM with Opthalmic Manifestations**	☐ DX code: _____
DM with Ketoacidosis	☐ DX code: _____	**DM with Neurological Manifestations**	☐ DX code: _____
DM with Hyperosmolarity	☐ DX code: _____	**DM with Peripheral Circulatory Disorders**	☐ DX code: _____
DM with other Coma	☐ DX code: _____	**DM with Other specified Manifestations**	☐ DX code: _____
DM with Renal Manifestations	☐ DX code: _____	**DM with Unspecified Complications**	☐ DX code: _____

2. This patient has the following co-existing conditions: **CHECK ALL THAT APPLY (If checking "Other" Please provide DX and description)**

Partial or complete amputation of the foo or kneet	☐ Amput great toe (Z89.411 RT) (Z89.412 LT) ☐ Amput other toe (Z89.421 RT) (Z89.422 LT) ☐ Amput foot (Z89.431 RT) (Z89.432 LT) ☐ Amput BK (Z89.511 RT) (Z89.512 LT) ☐ Amput AK (Z89.611 RT) (Z89.612 LT)	**Foot deformity**	☐ Charcot Foot with diabetes (E11.610) ☐ Hallux Valgus (M21.071 RT) (M21.072 LT) ☐ Hallux Rigidus (M20.21 RT) (M20.22 LT) ☐ Hammer Toe (M20.41 RT) (M20.42 LT) ☐ Pronation foot (M21.6X1 RT) (M21.6X2 LT) ☐ Foot Deformity (M21.961 RT) (M21.962 LT) ☐ Other: _____
Foot ulceration (If possible, code stage of ulcer and any contributable bacteria causing agent)	☐ Ulcer of heel and midfoot (L97.419 RT) (L97.429 LT) ☐ Ulcer other part of foot (L97.519 RT) (L97.529 LT) ☐ Other_____ ☐ Other_____	**Poor Circulation**	☐ Peripheral vascular disease, unspecified (I73.9) ☐ Poor Circulation (I87.2) ☐ Other_____
History of pre-ulcerative foot callus	☐ History of pre-ulcerative callus (Z86.31) ☐ Other_____	**Evidence of callus formation**	☐ Callus (L84)
Other Diagnosis	☐ Other _____	**Other Diagnosis**	☐ Other_____

3. Please provide the patient with the following: **CHECK ALL THAT APPLY**

☐ One pair of Therapeutic off the shelf Extra Depth Shoes, manufactured to accommodate multi-density Inlays.
☐ Three pairs of custom multi-density Inlays for therapeutic shoes.
☐ One pair of Diabetic Custom Foot Orthotics for Therapeutic Shoes.
☐ Toe Filler ☐RT ☐LT

By signing below, I state that the patient named above has diabetes and is being treated by me under a comprehensive plan of care.

Printed Physician Name: _____

PHYSICIAN SIGNATURE: * _____ Date: _____ NPI:_____

***INSURANCE REQUIRES M.D. OR D.O. SIGNATURE**