

### Detailed Written Order (Prescription)

Order valid for only 6 months from date of signature

PATIENT NAME \_\_\_\_\_ Phone# \_\_\_\_\_ DOB \_\_\_\_\_

**PHYSICIAN (PRINT)** \_\_\_\_\_ **DATE OF ORDER** \_\_\_\_\_

**I AM PRESCRIBING**

1 Pair A5500 Depth Inlay Shoes  3 Pair A5512 Heat Molded Multi-Density Inserts

Partial Foot Toe Filler  Right  Left

Other (Describe) \_\_\_\_\_

I certify that I am the prescribing. I have Reviewed this Detailed Written Order and confirm the prescribed and diagnosis are to the best of my knowledge accurate.

**Physician Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**NPI** \_\_\_\_\_ **Phone** \_\_\_\_\_ **Fax** \_\_\_\_\_

The Detail Written Order can be signed by a DPM, M.D. or D.O.

- ❖ PLEASE INCLUDE THE ORIGINAL PRESCRIPTION AND THE PRIMARY PHYSICIAN STATEMENT FILLED AND SIGNED.
- ❖ AND STATEMENT OF WHAT MEDICATION AND DOSAGE TAKEN FOR THE DIABETES

Office Visit Notes must be Dated and Signed.

**Please Fax to Either:**

**(201) 791-4995 - Fair Lawn**  
**(973) 473-8868 - Passaic**  
**(973) 484-4004 - Newark**

**Statement of Certifying Physician for Therapeutic Shoes and inserts**

Valid for only 6 months from date of signature



Fair Lawn Store: 26-17 Broadway, Fair Lawn, NJ 07410 | P: (201) 797-5355 | F: (201) 791-4995  
 Passaic Store: 361 Passaic St., Passaic, NJ 07055 | P: (973) 773-4566 | F: (973) 473-8868  
 Newark Store: 84 Broadway, Newark, NJ 07104 | P: (973) 482-8484 | F: (973) 484-4004

PATIENT NAME \_\_\_\_\_ PHONE# \_\_\_\_\_ DOB \_\_\_\_\_

PHYSICIAN (PRINT) \_\_\_\_\_ NPI \_\_\_\_\_

PHYSICIAN ADDRESS \_\_\_\_\_ Data \_\_\_\_\_

PHONE \_\_\_\_\_ FAX \_\_\_\_\_

I certify all of the following statements are true:

1. **This patient has diabetes mellitus**
2. **This patient has one or more of the following conditions: (check all that apply)**

- History of partial or complete amputation of the foot
- History of previous foot ulceration
- History of pre-ulcerative
- 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) because of his/her diabetes

Physician Signature \_\_\_\_\_ Data \_\_\_\_\_

The Statement of Certifying Physician may **only** be signed by a M.D. or D.O.

Statement signed by a D.P.M., N.P., C.N.A., M.A. are not allowed by Medicare

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