DIABETIC FOOT ASSESSMENT, M.D. / D.O.

DATE OF EXAMINATION: _____

PATIENT NAME: _____ DOB: _____

Type I Diabetes: _____Type II Diabetes: _____ Most Recent A1C: _____ Lab Value _____

NEUROLOGICAL: Vibratory or PIN Sensation: (R) Normal Diminishes Absent

(L) Normal Diminishes Absent

VASCULAR: Dorsalis Pedis: (R) Absent Weak Normal

(L) Absent Weak Normal

Posterior Tibial: (R) Absent Weak Normal

(L) Absent Weak Normal

Cap Fill:(R) Instant 1-sec 2-sec 3-sec (L) Instant 1-sec 2-sec 3-sec

DERMATOLOGIC: Hair: (R) _____ (L) _____

Skin Color: (R) _____ (L) _____

Skin Temp: (R) _____ (L) _____

Plantar Keratosis (Callus): (R) 1 2 3 4 5 MPJ Other: _____

(L) 1 2 3 4 5 MPJ Other: _____

Digital Keratosis (corns): (R) 1 2 3 4 5 (L) 1 2 3 4 5

Edema: (R) Pitting _____ Brawny _____

(L)Pitting _____ Brawny _____

Ulcer: (R) _____ (L) _____

FOOT DEFORMITY: (R) Bunion Hammertoes Bunionette

(L) Bunion Hammertoes Bunionette

Other: (R) _____ (L) _____

Amputation Foot: (R) Full Partial _____

(L) Full Partial _____

I have completed the above medical foot exam. I am treating this patient under a comprehensive plan for their diabetes.

Based on my findings indicated on the above assessment, this patient qualifies for extra depth therapeutic footwear and

_____A5513Custom fabricated full contact inserts *OR* _____ A5512 Direct formed, heat molded inserts

which are medically necessary to achieve and maintain contact with the plantar aspect of the patient's foot, and to help prevent irritation and tissue breakdown. I am also sending a certification statement so that the extra depth shoes and inserts can be ordered and dispensed for my patient. This examination is part of the medical record.

PHYSICIAN NAME: _____ M.D / D.O.

PHYSICIAN SIGNATURE: _____ DATE: _____