STATE OF OKLAHOMA
Oklahoma Health Care Authority
Statement of Certifying Physician for Therapeutic Shoes

Patient Name:_____

Member ID Number: _____

I certify that all of the following statements are true:

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

    a. History of partial or complete amputation of the foot

    b. History of previous foot ulceration

    c. History of pre-ulcerative callus

    d. Peripheral neuropathy with evidence of callus formation

    e. Foot deformity

    f. 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 shoes) because of his/her diabetes.

Physician Signature:_____

Date Signed:_____

Physician name (printed):

_____

Physician address:

_____

_____

_____