DIABETIC SHOE DAY

Tuesday April 15th, 2025

Kentucky Homeplace Office

Mckee, KY 40407

Kentucky Homeplace is hosting a diabetic shoe clinic at Kentucky Homeplace office on April 15th . If you have insurance and have met your deductible, these shoes will be at no cost to you. We have forms available that will need to be completed by your provider prior to this shoe clinic. We will have a certified Pedorthist here to help you. *To schedule appointment or for more information call Tim Marcum* @ Kentucky Homeplace 606-287-3756

Comprehensive Diabetes Foot Examination Form

Adapted from the National Diabetes Education Program's Foot Screening Form

Name: **Date:** **Age:**

Age at Onset: **Diabetes Type** ☐ 1 ☐ 2 **Current Treatment:** ☐ Diet ☐ Oral ☐ Insulin

I. Medical History
(Check all that apply.)
☐ Peripheral Neuropathy
☐ Cardiovascular Disease
☐ Nephropathy
☐ Retinopathy
☐ Peripheral Vascular Disease

II. Current History
1. Any change in the foot or feet since the last evaluation?
☐ Yes ☐ No
2. Current ulcer or history of a foot ulcer?
☐ Yes ☐ No
3. Is there pain in the calf muscles when walking that is relieved by rest?
☐ Yes ☐ No

III. Foot Exam
1. Are the nails thick, too long, ingrown or infected with fungal disease?
☐ Yes ☐ No

2. Note foot deformities.
☐ Toe deformities ☐ Bunions ☐ Charcot foot ☐ Foot drop
☐ Prominent metatarsal heads
☐ Amputation (Specify date, side and level.)

3. Pedal Pulses
(Fill in the blanks with a "P" or an "A" to indicate present or absent.)

Posterior tibial:	Dorsalis pedis:
Left	Left
Right	Right

4. Skin Condition (Measure, draw in and label the patient's skin condition using the key and foot diagram to the right.)

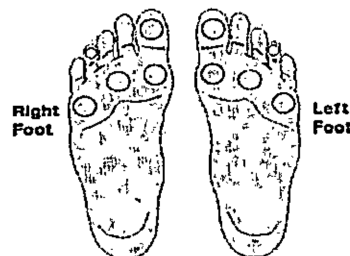
C = Callus R = Redness W = Warmth

F = Fissure S = Swelling U = Ulcer

M = Maceration PU = Pre-ulcerative lesion D = Dryness

IV. Sensory Foot Exam
Label sensory level with a "+" in the five circled areas of the foot if the patient can feel the 5.07 Semmes-Weinstein (10-gram) nylon filament and "-" if the patient cannot feel the filament.

NOTES *NOTES*



V. Risk Categorization (Check appropriate item.)
Low-Risk Patient
All of the following:
☐ Intact protective sensation ☐ No severe deformity
☐ No prior foot ulcer ☐ Pedal pulses present
☐ No severe deformity ☐ No amputation

High-Risk Patient
One or more of the following:
☐ Loss of protective sensation
☐ Absent pedal pulses
☐ Severe foot deformity
☐ History of foot ulcer

VI. Footwear Assessment
1. Does the patient wear appropriate shoes?
☐ Yes ☐ No
2. Does the patient need inserts/orthotics?
☐ Yes ☐ No

VII. Education
1. Has the patient had prior foot care education?
☐ Yes ☐ No
2. Can the patient demonstrate appropriate self-care?
☐ Yes ☐ No

VII. Management Plan (Check all that apply.)
☐ Provide patient education for preventive foot care. ☐ Refer to an APMA member podiatrist or an appropriate physician.

Date:________________ Provider Signature:________________

Statement of Certifying Physicians for Therapeutic Footwear

(The certifying physician must be the M.D. or D.O. caring for the patient's diabetic condition.)

Name: ______________________ Address: ______________________

City: ______________ State: KY ______________ Zip Code __________

Phone: ______________ DOB: ______________ Sex: ____

I certify that all of the following statements are true:

1) This patient has diabetes mellitus. ☐ yes ☐ no **ICD-10** Code: __________

2) This patient has **ONE OR MORE** of the following conditions and it is documented in their file.

(Check all that apply):

____History of partial or complete foot amputation ____Foot deformity (bunions, hammer toes, etc.)

____History of pre-ulcerative callous ____Poor circulation

____Peripheral neuropathy with callous formation ____Previous ulcer(s)

3) This patient needs special shoes (depth or custom-molded) and/or inserts because of their diabetic condition.

4) I am treating this patient under a comprehensive plan of care for his/her diabetes and my records reflect that the indicated diagnoses are present. As required by Medicare, if requested, I will provide copies of these records.

Prescription: ____ 1 pair of extra depth shoes (A5500) and 3 pairs of multi density inserts (A5512) that are heat molded to their feet for his/her diabetes.

____ For an amputee, 1 extra depth shoe (A5500) and 3 multi density inserts (A5512) that is heat molded to their foot for his/her diabetes.

____ 1 pair of extra depth shoes (A5500) and 3 pairs of custom molded multi density inserts (A5513)

Other ______________________________

Certifying Physician Information:

Name (Printed) ______________________ NPI#: ______________

XSignature: ______________________ Date: ______________

(The certifying physician must be the M.D. or D.O. caring for the patient's diabetic condition.)

Address: ______________________ City: ______________ State: KY

Zip: ______________ Phone: ______________ Fax: ______________

Fax Reply To:

Plaza Drug of London

731 North Laurel Rd London, Ky 40741

606-287- 3765

PH: 606-287-3756