Therapeutic Shoes & Inserts Certificate of Fitting

Patient Name____

Date of Birth ________________________________Phone Number (_____)____________________

Foot Measurements taken with Patient's Socks ON

Left Length ________ Left Width ________ Right Length _________ Right Width________

AA=Narrow& A-D=Medium& E=Wide& EE=X-Wide& (3E)=XX-Wide& (4E)=3X-Wide& (6E)=5X-Wide&

Recommended Shoe Order

Gender Women's& Men's&

Shoe Name/Style ______________________________

Cover Leather& Zennon&

Color Beige& Black& Brown& Taupe& White&

Closure Lace& Velcro&

Width ____________ Size _________ Alternate Shoe ____

Inserts Custom& Qty ea. 2& 4& 6& Pre-Fab& Qty ea. 2& 4& 6& None&

I acknowledge the following statements regarding my Diabetic Therapeutic Shoes and Inserts.

SAMPLE

- I have been measured for Therapeutic Footwear and / Inserts *Patient Initials* _______
- I have has placed my feet in an Impression Box in order to have Custom Inserts made for the recommended Therapeutic Shoes. *Patient Initials* _______
- I have read, understand, and agree to be bound by the terms and conditions set forth in the Rights Responsibilities and Sales Agreement. *Patient Initials* _______

HCPCS	Description	Quantity	Patient Initials
A5500	Left Shoe		
A5500	Right Shoe		
A5513	Custom Inserts		
A5512	Pre-Fab Inserts		

I have received the Therapeutic shoes, inserts in good condition and I am satisfied with the product(s).

✍I, Date:

(PATIENT SIGNATURE)

Patient satisfaction Notes:____

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Qualified Fitter:____ Date:__________