



Patient Name: _____ D.O.B: _____

Address: _____

City: _____ St: _____ Zip: _____ Phone: _____

The above patient has diabetic mellitus YES _____ NO _____

- Non-Insulin Dependant
- Insulin Dependant

Patient was last seen on _____
ICD-9 _____

PHYSICIAN'S PRESCRIPTION:

Please provide the above patient w/ the Following:

- One pair of therapeutic off the shelf depth-inlay shoes, manufactured to accommodate multi-density insert(s).
- Three pair of multi-density inserts for therapeutic shoes

Check all that apply.
This patient has one or more of the following:

- History of partial or complete amputation of the foot YES ___ NO ___
- History of previous foot ulceration YES ___ NO ___
- History of Pre-ulceration call us YES ___ NO ___
- Peripheral neuropathy with evidence of callus formation YES ___ NO ___
- Foot deformity YES ___ NO ___

By signing below, I state that the patient named above has diabetes and is being treated by me under a comprehensive plan of care for the patient's diabetes. All of the information contained in this statement is true and correct to the best of my knowledge.

By my signature below, I authorize the use of this document by a licensed pharmacy as a dispensing authorization.

Physician: _____ NPI: _____

Address: _____

City: _____ St: _____ Zip: _____ Phone: _____ Fax: _____

SIGNATURE: _____ Date: _____

If you fax this document, Medicare/Insurance requirements are that you maintain the signed original in the patient's medical record file for post-payment review audit purposes.

GabeCare Direct Rx • 1179 Maplelawn • Troy, MI 48084 • 800-422-3227

PLEASE FAX THIS FORM TO 1-877-699-6037