

**CERTIFICATION OF MEDICAL NECESSITY FOR  
THERAPEUTIC SHOES**

Patient Name: \_\_\_\_\_

This patient needs special shoes to prevent further deterioration of his/her foot condition as a complication of diabetes mellitus.

**Risk factors: (Check all that apply)**

- History of previous ulceration
- Callous formation
- Toe deformity (hammer-toe, claw-toe)
- Musculoskeletal deformity (hallux valgus)
- Poor circulation in legs/feet
- Diabetic neuropathy
- Other \_\_\_\_\_

**Recommendations:**

Standard good-quality orthopedic or athletic shoe

- Roomy toe box (wide, rounded)
- Wide width
- Extra depth
- Seamless, non-abrasive lining
- Adjustable closure (laces or velcro)
- Rocker sole

Preferred

- Insole cushioning
- Removable insole
- Customizable insert

Physician name (printed): \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_