Central Kansas Podiatry Associates

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State of the Art Podiatric Care

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STATEMENT OF CERTIFYING PHYSICIAN

PATIENT NAME_____CHART #_____ DATE_____

PLEASE CHECK ALL THAT APPLY:

DIABETES TYPE:

____ Type I

____ Type II

PRIMARY DIAGNOSIS

__Claw toe (735.5)
__Hallux rigidus (735.2)
__Hallux valgus (735.0)
__Hammer toe (735.4)
__History of pre-ulcerative callus (707.9)
__Lower limb amputation, foot (V49.73)
__Lower limb amputation, lesser toe(s) (V49.72)
__Ulcer of heel and midfoot (707.14)
__Ulcer other part of foot (707.15)
__Unspecified deformity of ankle and foot, acquired (736.70)
__Unspecified acquired foot deformity of toe (735.9)

"I certify that I am managing this patient's diabetes that my records reflect that the indicated diagnoses are present. As required by Medicare, if requested, I will provide copies of these records."

MD/DO/NAME_____

Phone_____ Fax_____ Address_____

SIGNATURE:_____ DATE: _____ Upin: _____

Heel Pain.Bunions.Hammertoes.Tumors.Fractures.Ingrown Nails.Trauma.Wound Care.Orthotics.Diagonostic Ultrasound.Diabetic Shoes.Physical Therapy.Bracing.DME