

**Patient Name:**  **Date:**  /  /  **Our Medical Record #:**

**Name of Office/Clinic performing CDFE:**

**Name of MD/DO Supervising Diabetes Management:**

(Please sign Certifying Physician Acknowledgment below)

Date of last palliative foot care: / /	Date last seen by Certifying Physician: / /
Date of last CDFE: / /	Last FBS: Date: / /
Past medical history:	Last HbA1c: Date: / /
Medications:	Allergies: Estimated duration of Diabetes:
Foot Complaints:	ICD9 Code (MD/DPM to fill in):

**REVIEW OF SYSTEMS (check all applicable):**

- Ortho:**  Joint Aches/Pains  Deformities  Stiffness  Weakness
- Derm:**  Skin Rash  Pruritus  Nail Changes  Scaling  Dryness
- Neuro:**  Numbness  Tingling  Paresthesia  Dysesthesia  Hypesthesia
- Vascular:**  Claudication  Night Cramps  Edema  Temp. Changes
- Endocrine:**  Polyuria  Polydipsia  Polyphagia
- Co-Morbidities:**  Retinopathy  Nephropathy  Other \_\_\_\_\_

**PHYSICAL EXAM:**

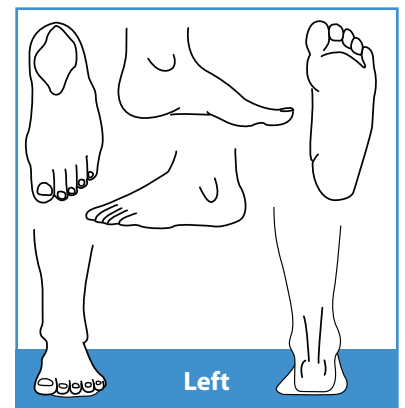
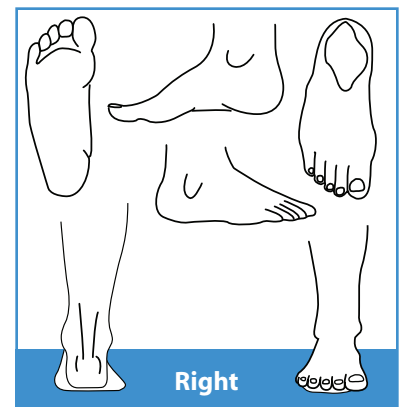
**Orthopedic** (PQRI 127, 163)

	Left	Right
Digital Deformities (including hallux valgus)		
Equinus		
Plantarflexed Metatarsals		
Charcot Deformities		
Previous Amputations		
Other		
<b>PressureStat® Assessment:</b>		
Quantified areas of excessive pressure in excess of 6 kg/cm2		
Foot Type (e.g., Pes Cavus, Pes Planus)		

**Dermatological** (PQRI 127, 163)

	Left	Right
Tinea Pedis		
Xerosis		
Skin Fissure		
Ulceration		
Gangrene		
Infection Locations (e.g., Current, Past)		
Onychomycosis		
Interdigital Spaces, etc.		
<b>TempStat® Assessment</b>		
Contralateral Temperature Comparison (note if right and left foot are similar)		
Areas of Increased Focal Temperature		

Note excessive pressure areas below:



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Neurological (PQRI 126, 127, 163)	Left	Right
Vibration Perception		
Loss of Protective Sensation (# of sites)		
DTR		
Sharp/Dull		
Other		

Vascular (PQRI 127, 163)	Left	Right
Dorsalis Pedis		
Posterior Tibial		
Capillary Refill Time		
Other		

**FOOTWEAR EVALUATION**

Describe

Type of Shoe (e.g., Brand Name, Model, Size and Width) \_\_\_\_\_

Fit:  Good  Too Loose  Too Tight  Too Narrow  Too Wide  Inappropriate

Foreign Bodies \_\_\_\_\_

Innersoles  Orthotics  Therapeutic Inserts (e.g., Heat Molded, Custom)

Shoe Condition/Wear Pattern:  Good  Irreparable/Replace  Excessive Wear (Location: \_\_\_\_\_ )

Other \_\_\_\_\_

**RISK STRATIFICATION (recommended exam frequency)**

(0) No Neuropathy – Annual  (1) Neuropathy – Semi-Annual  (2) Neuropathy, PVD and/or Deformity - Quarterly  (3) Previous Ulcer or Amputation – Monthly to Every Two Months

**EDUCATION AND COUNSELING (minimum 50% time spent)**

Completed

General	Explanation of systemic risks of diabetes and importance of proper glucose control.	
	Explanation of dangers of neuropathy or excessive pain	
	Counseling on risk stratification and exam frequency	
PressureStat <sup>®</sup> Education	Explanation of high pressure areas, risks and offloading solutions	
	Review proper foot care instructions (on reverse side of PressureStat)	
TempStat <sup>®</sup> Education	Explanation of inflammation, "hot spots" and ulcer formation	
	Counseling on proper daily self-examination and monitoring of feet	
Medications	Review of current medications	
Other	Discussed use of Appropriate Therapeutic Footwear, Inserts, and Orthotics	

Prescriptions Ordered: \_\_\_\_\_ Shoe and Insert/Orthotic Rx: \_\_\_\_\_

\_\_\_\_\_ Rationale: \_\_\_\_\_

Referred To: \_\_\_\_\_ (physician's name) Next CDFE Exam: \_\_\_\_\_

Reason: \_\_\_\_\_ Diagnostic Studies (e.g., Imaging Studies, Vascular Testing, Nerve Biopsy, etc.): \_\_\_\_\_

Patient Visit: Time in: \_\_\_\_\_ Time Out: \_\_\_\_\_ Physician Performing CDFE Signature and Title: \_\_\_\_\_

**Certifying Physician Acknowledgment:**

I am the physician managing the above patient's diabetes under a comprehensive plan of care. This note has been incorporated as part of my patient's medical record. I agree that the findings above are consistent with the patient's secondary foot findings. I agree the patient requires therapeutic shoes and inserts.

Print Name: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Certifying Physician Signature and Title: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Please mail/fax this back to us with the attached Certifying Physician's Statement and keep a copy of both forms in the patient's chart. Thank you.**

