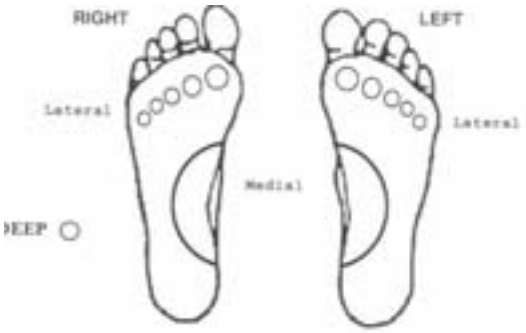
DIABEST, INC.

FOOT EVALUATION FORM

Patient:_____ Tel:_____	Physician:_____ Tel:_____
Address:_____	Address:_____
_____ DOB:_____	UPIN/ NPI #: _____ Medicaid #:_____
Sex: Ht: Wt: Insurance: /	Diag1: Diag2: Diag3: Diag4:

Foot Evaluation

☐ High/Mid/Low Arch ☐ Hammer toes ☐ Bunions ☐ Swelling ☐ Calluses ☐ Ulcer ☐ Fracture ☐ Amputation



Measurement Right Foot:_____ Left Foot:_____ Width:_____

Device(s) Information

Sizes/ Widths Recommended: 4, 4 ½, 5, 5 ½, 6, 6 ½, 7, 7 ½, 8, 8 ½, 9, 9 ½, 10, 10 ½, 11, 11 ½, 12, 12 ½, 13, 14 ☐ M ☐ W ☐ XW

Lace: ☐ Velcro: ☐ Color: _____ Company Name: _____ Model: _____

Pairs of Inserts ☐ 0 ☐ 1 ☐ 2 ☐ 3 Special order: _____

_____

Follow – Up Chart

Category	Monofilament	Protective sensation	Insert	Ulcer	Deformity	Follow-Up
A.	5.07 (10gm)	yes	cushion	no	no	12 months
B.	5.07 (10gm)	no	molded	no	no	6 months
C.	5.07 (10gm)	no	molded	no	yes	4 months
D.	5.07 (10gm)	no	molded	history of	yes	3 months
E.	6.10 (75gm)	no	molded	yes	yes	2 months

Date	Progress Note

Complete By: Date: