CLIENT INFORMATION

<table>
<thead>
<tr>
<th>Client’s name (last)</th>
<th>(first)</th>
<th>Date of Birth</th>
<th>Personal Health Number</th>
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Specialty Supplier Name | Phone Number

This questionnaire MUST be completed prior to determining eligibility for Custom Footwear and/or completing on-line authorization.

1. Does the client have over sized feet or under sized feet? Yes □ No □
   
   If yes, do not proceed, as client’s needs can be met with off-the-shelf footwear.

2. Does the client have split sized feet or a pre-op or post-op need? Yes □ No □
   
   If yes, do not proceed, as client’s needs can be met with off-the-shelf footwear.

3. Does the client have edema? Yes □ No □
   
   If yes, has the edema been:
   
   a) Investigated? If no, refer back to their physician.
   b) Reduced & stabilized? If no, refer the client back to their physician.
   c) Have other measures been trialed to control the edema, such as compression stockings? If no, please explain why not:

   __________________________________________________________________________________
   __________________________________________________________________________________
   __________________________________________________________________________________

4. Has the client tried therapeutic shoes or off-the-shelf footwear? Yes □ No □
   
   If no, do NOT proceed
5. What types of shoes or off-the-shelf footwear did the client try?

___________________________________________________________________

___________________________________________________________________

6. Where and when did this trial of therapeutic shoes and/or off-the-shelf footwear occur?

___________________________________________________________________

___________________________________________________________________

Comments and/or recommendations:

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

7. Has the client tried the off-the-shelf foot orthotics?  

Yes □  No □

If yes, state outcome:

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

8. Has the client tried custom-made foot orthotics?  

Yes □  No □

If yes, state outcome & name of facility that fabricated the orthotics:

___________________________________________________________________

___________________________________________________________________

9. Has the client significant bony deformity or stabilized gross chronic Lymphedema of the foot that prevents the client from wearing a modified therapeutic shoe with rocker soles, tongue padding, flares and/or stretching that results in a functional footwear fitting?  

Yes □  No □
10. If no, will Custom Footwear enable the client to ambulate?  
   Yes ☐  No ☐

11. Additional Comments:

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

AADL does not provide Custom Footwear for non-ambulatory clients and/or for assisting in pivot or standing transfers

Specialty Supplier’s signature:________________________Date:__________________