# Therapeutic Footwear Prescription

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Please fill out all information. Incomplete forms cannot be accepted by Specialty Suppliers. Therapeutic Footwear Prescriptions can only be completed by a Nurse Practitioner or Physician who is a member of a multidisciplinary high-risk foot team, or an Occupational Therapist, Physical Therapist or Registered Nurse found on the list of AADL-Recognized High Risk Foot Team found on the AADL website.

<table>
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<tr>
<th>Client Information</th>
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<td>Name:</td>
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**Diagnosis:**

- [ ] 0 – No loss of protective sensation
- [ ] 1 – Loss of protective sensation
- [ ] 2 – Loss of protective sensation with high pressure (callus/deformity) or poor circulation
- [ ] 3 – History of ulceration or neuropathic fracture

- ABI: (R) ____________ (L) ____________
- PPG: (R) ____________ (L) ____________

**Clinical Indicators:**

- □ Nocturnal pain
- □ Loss of hair on foot and toes
- □ History of gangrene
- □ Pain at rest
- □ Cyanosis
- □ Dependent rubor/blanching on elevation
- □ Chronic, non-healing ulcer with no or limited healing potential
- □ History of a lower extremity ulcer
- □ Healed ischemic foot ulcer
- □ Bony deformity with digit pressure ulcer history
- □ Other: ________________________________________________________________

**Therapeutic Footwear Recommendations**

- □ Pressure Downloading Orthosis (air cast or healing sandal with custom insert) ➔ A Pressure Downloading Orthosis **MUST** be required for at least six months to be eligible for funding by AADL.
  - Pressure Downloading Orthosis is required for: _______ months

- □ Therapeutic Shoes ➔ Specify brand:
  - □ PW Minor
  - □ Ambulator
  - □ Other specific brand: ____________________________

- □ Total Contact Inserts ➔ Comments:
  - __________________________________________________________________________
  - __________________________________________________________________________

- □ Shoe Modification(s):
  - □ Rockers:__________________________________
  - □ Flares:___________________________________
  - □ Lift (< ¾“):________________________________
  - □ Velcro Closures:____________________________
  - □ Stretch:___________________________________
  - □ Other:____________________________________

**Therapeutic Footwear Prescriber Information**

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<thead>
<tr>
<th>Name:</th>
<th>Date:</th>
<th>Signature:</th>
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<tr>
<td>Clinic/Facility:</td>
<td>Registration Number:</td>
<td>□ MD □ NP □ OT □ PT □ RN</td>
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(2018/07)