

# DOCUMENTATION OF IN-PERSON FITTING AND DISPENSING FOR DIABETIC FOOTWEAR

Performed by:   
Clinic Name:   
Patient Name:   
Record/ID #:   
PCP (MD/DO):   
Prescriber:

## Checklist for Required Documents

- Statement of Certifying Physician (CMN) Received
- Prescription Received
- Shoe Care & Use Instructions Provided
- CMS DMEPOS 26 Supplier Standards Provided
- Delivery Receipt & Authorization for Payment Signed

*This form was designed by  
Dr. Comfort for use by  
qualified health professionals.*



## INITIAL FITTING AND ASSESSMENT

Met with patient in-person on \_\_\_\_\_ at \_\_\_\_\_  
(date) (location)

INITIALS: \_\_\_\_\_

Patient comments regarding needs: \_\_\_\_\_

Observations of feet with socks off (  Check box if foot exam form also used and included in file): \_\_\_\_\_

Any open sores?  No  Yes (If yes, do NOT continue with fitting. Refer back to physician for treatment.)

Diagnosis-specific issues from prescription to be considered: \_\_\_\_\_

Recommendations / Sizing (  Check box if fitting form also used and included in file): \_\_\_\_\_

## DISPENSING OF FOOTWEAR

Met with patient in-person on \_\_\_\_\_ at \_\_\_\_\_  
(date) (location)

INITIALS: \_\_\_\_\_

Patient comments regarding fit: \_\_\_\_\_

Fitter comments regarding fit / accommodations made at time of dispensing: \_\_\_\_\_

Number of heat-moldable inserts molded to patient (if applicable): \_\_\_\_\_

Follow-up instructions to patient and plan of care: \_\_\_\_\_

## FITTER'S SIGNATURE

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_