AuBurn Pharmacy
Pt Services Chapter 8

FINAL FITTING OF DIABETIC SHOES

PATIENT NAME: _____ DATE OF FITTING _____ ☐ IN PERSON VISIT DOCUMENTED

ADDRESS: _____ DOB: _____

ALL AREAS REVIEWED AT TIME OF FINAL FITTING:

LENGTH OF SHOE CORRECT: YES___ NO___ OTHER, PLEASE DOCUMENT PROBLEM AREA BELOW

_____

WIDTH OF SHOE CORRECT: YES___ NO___ OTHER, PLEASE DOCUMENT PROBLEM AREA BELOW

_____

DEPTH OF SHOE CORRECT: YES___ NO___ OTHER, PLEASE DOCUMENT PROBLEM AREA BELOW

_____

PATIENT FOOT STATUS AT TIME OF FINAL FITTING/ DELIVERY OF SHOES

	YES	NO	OTHER, PLEASE EXPLAIN
PAIN	☐	☐	☐
REDNESS	☐	☐	☐
SWELLING	☐	☐	☐
MOBILITY	☐	☐	☐
SORENESS	☐	☐	☐

_____

_____

DIABETIC SHOE BREAK IN FORM PROVIDED AT TIME OF FINAL FITTING YES____ NO ____
DO YOU CURRENTLY HAVE ANY OTHER CONCERNS WITH YOUR DIABETIC SHOES? YES____ NO ____

_____

_____

DID CUSTOMER WALK AROUND IN THE SHOE AND DETERMINE IF ANY AREAS OF CONCERN ARE PRESENT?
YES____ NO ____ IF AREA OF CONCERN PLEASE DOCUMENT: _____

_____

DID PROVIDER HEAT MOLD INSERTS TO THE CUSTOMER? YES____ NO ____ IF ANY PROBLEMS PLEASE EXPLAIN_____

_____

IS THERE ANY SLIPPING IN THE HEAL? YES ____ NO ____
IS THE CUSTOMER WEARING THE HOSE, SOCKS, ETC: THAT THEY WILL BE WEARING WITH THE DIABETIC SHOES? YES___ NO___

DO THE SHOES FIT THE NEED OF THE CUSTOMER AT THIS TIME? YES___ NO ____
DO ANY MODIFICATIONS NEED TO BE MADE TO THE FIT OF THE SHOE? YES ___ NO ___ IF ANY PLEASE EXPLAIN _____

ADDITIONAL NOTES:

_____

_____

FOLLOW-UP VISIT RECOMMENDED ☐ _____ FOLLOW-UP BY PHONE & AS NEEDED ☐

Employee Signature _____ Date of final fitting _____

REVISED 03/31/2015