STANDARD WRITTEN ORDER

*Must provide office notes of foot exam

Patient Information:
Name: _____
Address: _____
City/St/Zip: _____
Phone: _____
Dob: _____

Provider Information:
Kesling Home Health Care LLC
1115 W. Market St., P.O. Box 328
Logansport, IN 46947
Phone: 574-735-0082 /Fax:574-753-3910
NPI: 1568642056 / TAX ID: 351994022

Check all that apply:

□ Diabetes Mellitus □ Callus(es) □ Corn(s) □ Bunion(s) □ Hammer toe(s) □ Ulcer(s)

□ Amputation(s) □ Charot Deformity □ Neuropathy with evidence of callus formation

□ Poor Circulation □ Other:_____

Patient Requires (check all that apply):

□ Therapeutic Footwear, non custom (A5500) – 1 Pair (unless otherwise indicated)

□ Heat Moldable Inserts, non custom (A5512) – 3 Pair (unless otherwise indicated)

□ Custom Molded Inserts (A5513) – 3 Pair (unless otherwise indicated)
- □ Lesions requiring offloading (if necessary)
- □ Left □ 1 □ 2 □ 3 □ 4 □ 5
- □ Right □ 1 □ 2 □ 3 □ 4 □ 5

□ Toe Filler (L5000)
- □ Indicate missing digits
- □ Left □ 1 □ 2 □ 3 □ 4 □ 5
- □ Right □ 1 □ 2 □ 3 □ 4 □ 5

Physician's Signature:_____ Date:_____

Physician's Information: (Please correct the following information, if necessary)

Name: _____ NPI:_____
Address: _____
City: _____ State: _____ Zip: _____

Phone #: (_____)-_____-_____ Fax #: (_____)-_____-_____