**Custom Foot Orthotic Tool**

**Instructions:**

The supplying provider shall provide this form to the referring provider for completion.

An orthotist may provide the information required in the fields with asterisks.

The supplying provider submits the completed form to Vermont Medicaid via fax at (802) 879-5693

Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Member Name:

Prescriber/Evaluator Name:

Orthotist Name:

Member Medicaid #:

Prescriber/Evaluator Medicaid #:

Orthotist Medicaid #:

|  |  |
| --- | --- |
| Age | Click here to enter text. |
| Height/weight | Click here to enter text. |
| Primary Diagnosis | Click here to enter text. |
| Co-morbidities | Click here to enter text. |
| Relevant history | Click here to enter text. |
| Activity level | Click here to enter text. |
| Current footwear | Click here to enter text. |
| Recommendations for footwear changes | Click here to enter text. |
| Pertinent range of motion concerns | Click here to enter text. |
| Foot skin impairments | Click here to enter text. |
| Foot bony impairments | Click here to enter text. |
| Related joint abnormalities (ankle, knee, hip, back) | Click here to enter text. |
| Conservative treatment to date (including specific medications, compression, taping, rest, splinting, elevation, unweighting, ice/heat, ambulatory assistive devices, exercise, self-mobilization) | Click here to enter text. |
| Other treatment: (include surgeries, injections)  | Click here to enter text. |
| Prefabricated orthotics: | * Unsuccessful trial of good quality prefabs: [ ]  Yes [ ]  No
* Unsuccessful trial of formed-to foot orthotics: [ ]  Yes [ ]  No
* Reason why prefabs and formed-to-foot orthotics cannot meet the medical need: Click here to enter text.

Note: no review can occur without the above trial/consideration. Medicaid covers prefabricated and formed-to-foot orthotics. |
| Specify the home program/education provided | Click here to enter text. |
| \*Gait presentation | Click here to enter text. |
| \*Leg length measurements (if significantly unequal, document plan for lift) | L Click here to enter text. R Click here to enter text. |
| \*Static foot alignment impairments | Click here to enter text. |
| \*Dynamic foot alignment impairments | Click here to enter text. |
| \*Rationale for the specific orthotic code requested: | L3000: [ ]  Rearfoot control via a deep molded heelcup [ ] Rear and forefoot control via high medial and lateral sidesL3010: [ ]  Forefoot control/shock absorption/ alignment through longitudinal supportL3020: [ ]  Forefoot control/shock absorption/alignment through metatarsal **and** longitudinal support [ ]  Control of toe/metatarsal positioning through metatarsal support |
| \*Invoice amount | Click here to enter text. |
| Comments: Click here to enter text. |