VERMONT

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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 marked with asterisks (*).
- The supplying provider keeps this form in the clinical record.

Date: ____/____/_____

Member Name: Member Medicaid #:

Prescriber/Evaluator Name: Prescriber/Evaluator Medicaid #:

Orthotist Name: 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 heel cup ☐Rear and forefoot control via high medial and lateral sides L3010: ☐ Forefoot control/shock absorption/ alignment through longitudinal support L3020: ☐ 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.	

*An orthotist may complete these fields.