**Custom Foot Orthotic Tool**

**Instructions:**

**Documentation: The referring provider completes this form. The orthotist may assist by completing the asterisked segments.**

**Submission: Completed forms are submitted by the orthotist or Durable Medical Equipment supplier to VT Medicaid. Please  fax to 802 879 5963.**

Beneficiary Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Beneficiary Medicaid Number: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Prescriber/evaluator Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Prescriber/evaluator Medicaid Number: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Orthotist Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Orthotist Medicaid Number: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_**

MD/PT signature: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

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| --- | --- |
| 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. |

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| --- | --- |
| 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. |
| \*May be completed by orthotist. |