William W. Backus Hospital
Diabetic Foot Clinic
Referral Form

Backus Outpatient Care Center
111 Salem Turnpike
Norwich, CT 06360
Phone: 860-425-8700
Fax: 860-889-4708

This is to certify that _____place patient label here_____, DOB:___/___/___, is currently under my care for the treatment of his/her diabetes. The patient was last seen at my office on_____.

I certify that the following checked statements are true:

Diagnosis **ICD-9 Code**
(please circle / check all that apply):

Diabetes mellitus Type I - Type 2 with the following complication(s):

□ with renal manifestations	250.40
□ with ophthalmic manifestations	250.50
□ with neurological manifestations	250.60
□ with peripheral manifestations	250.70
□ other:_____	_____

Also complicated by:

□ difficulty walking	719.7
□ abnormality of gait	781.2
□ disease of nail	703.8
□ pain, foot	729.5
□ dermatophytosis of nail	110.1
□ onychia of toe	681.11
□ bunion	727.1
□ other:_____	_____

Physican Signature:_____

Insurance:_____

(PLEASE NOTE: FORM MUST BE COMPLETE IN ORDER TO BOOK APPOINTMENT)