Orthotics Referral
Post Completion of Total Contact Casting (TCC)

Orthotist Clinic:________________________________

Client Information
Name:
PHN:
DOB:

Month/Year client diagnosed with Diabetes____________ □ **Type 1** □ **Type 2**

Date of Onset Diabetic Foot Ulcer (DFU)#1 :_____________ **Date of Onset Diabetic Foot Ulcer (DFU)#2:**____________

History of previous Diabetic Foot Ulcer(DFU): □ **Yes** □ **No**

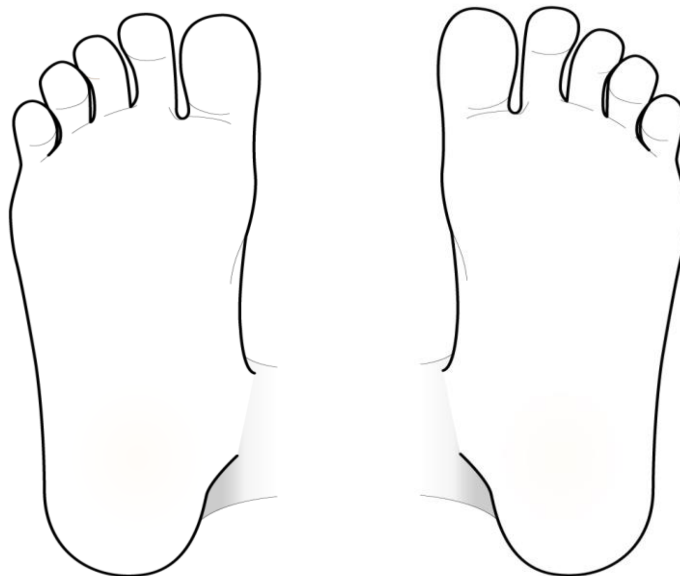
History of Charcot : □ **Yes** □ **No**

TCC Application Date: ________________________

Anticipated Wound Closure/TCC Removal Date: ____________________

Location of DFU(s):

Mark location of current DFU(s) with an X and identify if #1 or #2 ; mark location of previous DFU(s) with a O and identify if #1 or #2



Date: _____________________

Signature:_______________________________________ **(print):**______________________________________
Physician/NP/NSWOC/WC

Outpatient/Ambulatory Clinic HA: _____**Name:**_____________________________ **Phone Number:**_____________