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**

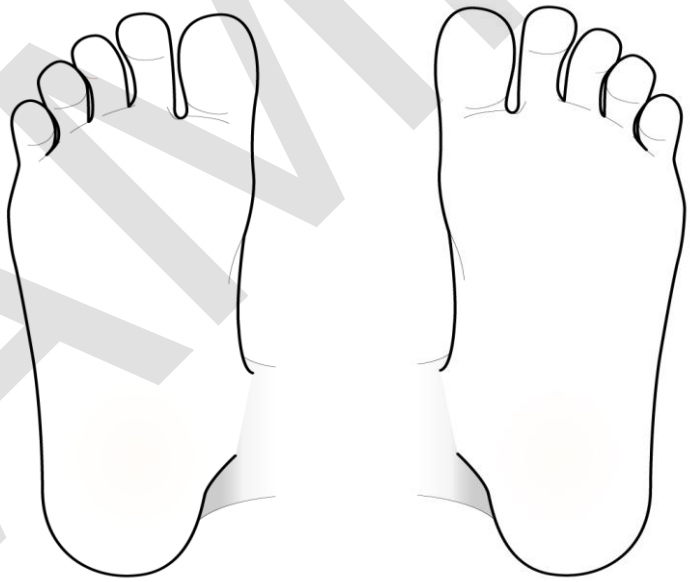
History of Charcot : □ **Yes** □ **No**

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:**_____

NSWOC Name(print):_____ **Phone Number:**_____

Outpatient/Ambulatory Clinic Name:_____