

# **ADVANCED MEDICAL SUPPLY,**

## **INC**

3322 N MILWAUKEE AVENUE  
CHICAGO, IL 60641  
PHONE: 773-205-6993  
FAX: 773-205-6994



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### FACSIMILE TRANSMITTAL SHEET

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TO:	FROM:
Allison L Curran NP/ Dr. Niraj Shah	Alex U.
PHONE: 815-726-2200	DATE:
FAX: 815-582-3253	10-25-24
RE: PATIENT NAME: Nasim Hafeez DOB: 12/1/1954	TOTAL NO. OF PAGES INCLUDING COVER: 2

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URGENT     FOR REVIEW     PLEASE COMMENT     PLEASE REPLY     PLEASE RECYCLE

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NOTES/COMMENTS:

Please fill out the attached forms and most recent clinical, then send them back to me at 773-205-6994 - Fax

If you have any questions feel free to contact us at 773-205-6993.

*Thank you very much for your cooperation.*

*Sincerely, Alex.*

**THE INFORMATION CONTAINED IN THIS MESSAGE IS INTENDED ONLY FOR THE PROFESSIONAL AND CONFIDENTIAL USE OF THE DESIGNATED RECIPIENT(S).** This message and/or any attachments thereto may be confidential, legally privileged, and/or exempt from disclosure under applicable law. If the reader of this message is not an intended recipient, you are hereby notified that any review, use, disclosure, dissemination, forwarding or copying of this email message and/or attachments or taking of any action in reliance on the contents therein is strictly prohibited. Please notify Advanced Medical Supply, Inc immediately by telephone or fax, and destroy the message received in error. Thank you.

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Advanced Medical Supply  
3322 N. Milwaukee Avenue, Chicago, IL 60641  
Phone: (773) 205-6993 Fax: (773) 205-6994

## WRITTEN DETAILED ORDER

PATIENT NAME: Nasim Hafeez  
DOB: 12/1/1954  
ID #: 216136689  
ADDRESS: 14440 Independence Drive, Plainfield, IL, 60544  
PHONE: 815-507-3435

**Rx**

**PRODUCT DESCRIPTION**

**QUANTITY**

**Rollator with seat, brakes and bucket.**

**1**

Height: 5'4"

Weight: 160 lbs

**LENGTH OF NEED (# OF MONTHS): 99=LIFETIME**

**DIAGNOSES:**

[ ] Alzheimer's disease  
[ ] Amputation of \_\_\_\_\_  
[ ] Unsteady gait  
[ ] Bronchial Asthma  
[ ] Dysphagia  
[ ] Malnutrition  
[ ] Chronic Incontinence [ ] Urine [ ] Stool  
[ ] CVA  
[ ] CHF  
[ ] Degenerative Osteoarthritis of \_\_\_\_\_  
[ ] Diabetes Mellitus

[ ] Dementia  
[ ] Dizziness  
[ ] Emphysema/COPD/Asthma  
[ ] Fracture of \_\_\_\_\_  
[ ] Generalized Body Weakness  
[ ] Hernia (inguinal) (umbilical) (ventral)  
[ ] Organic Brain Syndrome  
[ ] Osteoporosis \_\_\_\_\_  
[ ] Paralysis  
[ ] Parkinson's disease  
[ ] Varicose Veins/ Venous Insufficiency

[ ] Pendulous Abdomen  
[ ] Loss of Appetite  
[ ] Loss of Weight  
[ ] Renal Failure  
[ ] S/P CVA/Hemiparesis  
[ ] Carpal Tunnel Syndrome  
[ ] S/P Open Heart Surgery  
[ ] Debility  
[ ] Spondylosis (cervical) (lumbar)  
[ ] Sprain/Strain of \_\_\_\_\_  
[ ] HTN

I, the undersigned, certify that the above prescribed supplies/equipment are medically necessary for this patient's well being. In my opinion, the supplies are both reasonable and necessary to the accepted standards of medical practice in treatment of this Patient's condition and are not prescribed as convenience supplies. By signing this form, I am confirming that the above information is accurate.

### DOCTOR'S INFORMATION

Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Print Name: \_\_\_\_\_ NPI#: \_\_\_\_\_  
Facility Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_