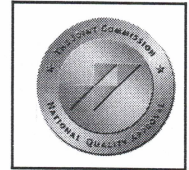


ADVANCED MEDICAL SUPPLY, **INC**

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



FACSIMILE TRANSMITTAL SHEET

TO:	FROM:
Lana Tymouch, PA-C, AQH	Alex U.
FAX: 773-975-3289 312-583-7897	DATE:
Office: 773-975-6775	09-10-2024 09-19-24.
RE:	TOTAL NO. OF PAGES INCLUDING COVER:
Olha, Fetsenets 11/10/1941	3

☒ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☒ PLEASE REPLY ☐ PLEASE RECYCLE

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.

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

DETAILED WRITTEN ORDER

PATIENT'S NAME: Olha, Fetsenets
DOB: 11/10/1941 Insurance No: 421934720
ADDRESS: 4938 N Menard Ave 2FL Chicago IL 60630

R x

PRODUCT DESCRIPTION

QUANTITY

Lightweight manual wheelchair with elevating footrests, safety belt, adjustable arm rest, heel holder-loops and anti-tippers.	1
General use wheelchair seat cushion.	1
General use wheelchair back cushion.	1

Height: 5'1"

Weight: 132 lb

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

DIAGNOSES:

- | | | |
|---|--|--|
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Dementia | <input type="checkbox"/> Pendulous Abdomen |
| <input type="checkbox"/> Amputation of _____ | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Appetite |
| <input type="checkbox"/> Unsteady gait | <input type="checkbox"/> Emphysema/COPD/Asthma | <input type="checkbox"/> Loss of Weight |
| <input type="checkbox"/> Bronchial Asthma | <input type="checkbox"/> Fracture of _____ | <input type="checkbox"/> Renal Failure |
| <input type="checkbox"/> Dysphagia | <input type="checkbox"/> Generalized Body Weakness | <input type="checkbox"/> S/P CVA/Hemiparesis |
| <input type="checkbox"/> Malnutrition | <input type="checkbox"/> Hernia (inguinal) (umbilical) (ventral) | <input type="checkbox"/> Carpal Tunnel Syndrome |
| <input type="checkbox"/> Chronic Incontinence <input type="checkbox"/> Urine <input type="checkbox"/> Stool | <input type="checkbox"/> Organic Brain Syndrome | <input type="checkbox"/> S/P Open Heart Surgery |
| <input type="checkbox"/> CVA | <input type="checkbox"/> Osteoporosis _____ | <input type="checkbox"/> Debility |
| <input type="checkbox"/> CHF | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Spondylosis (cervical) (lumbar) |
| <input type="checkbox"/> Degenerative Osteoarthritis of _____ | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Sprain/Strain of _____ |
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Varicose Veins/ Venous Insufficiency | <input type="checkbox"/> 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: _____



Standard Manual Wheelchair Questionnaire

Participant's Name Olha, Fetsenets RIN 421934720 Birth Date 11/10/1941

Height 5'1" Weight 132 lbs Participant's Hip Width 17"

Procedure code and description of wheelchair

K0003 - WHEELCHAIR, LIGHTWEIGHT

Weight capacity of wheelchair 350 lbs Width of wheelchair 18"

Diagnosis

Current ambulation status

Upper body control and strength

Does participant have the ability to self propel? Yes ☐ No ☐

If not, why?

If the participant is unable to safely self-propel the manual wheelchair does he/she have a caregiver who is available, willing, and able to provide assistance with the wheelchair? Yes ☐ No ☐

Does the participant need wheelchair to meet activities of daily living over the use of a walker or cane? Yes ☐ No ☐

If not, why?

Is this being requested for temporary use for injury or post op? Yes ☐ No ☐

If yes, date of injury or surgery _____ Expected duration of need _____

*All requests for renewal of post surgical/post injury wheelchairs will require updated MD script along with copy of MD clinical follow-up progress note.

Will this manual wheelchair meet participant's long term needs (3-5 years) or will participant need a customized wheelchair?

Physician's Name _____ Telephone Number _____

Attending Physician's Signature _____ Date Signed _____