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

DETAILED WRITTEN ORDER

Patient's Name:	Tyler, Ramona	
Address:	9137 S Emerald Ave Chicago, Il 60620	
Phone:	773-575-3942-cell, 773-575-3943- Sherell Dtr	
DOB:	08/18/1968	
Insurance Name and ID.	Medicare:	Medicaid: 065816472
Other Insurance Name and ID : MERIDIAN HEALTH PLAN INC MMCP		

R x

PRODUCT DESCRIPTION	QUANTITY
Pull ups/Diapers	200
Liners	120
Underpads	150
Gloves	200

Height: 5'1'' Weight: 160 LB

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

DIAGNOSES:

[ ] Stress incontinence (female) (male)	[ ] Fecal smearing	[ ] Emphysema/COPD/Asthma
[ ] Urge incontinence	[ ] Fecal urgency	[ ] Dementia
[ ] Incontinence without sensory awareness	[ ] Full incontinence of feces	[ ] Diabetes Mellitus
[ ] Post-void dribbling	[ ] Drug induced retention of urine	[ ] Renal Failure
[ ] Nocturnal enuresis	[ ] Other retention of urine	[ ] CHF
[ ] Continuous leakage	[ ] Retention of urine, unspecified	[ ] Dysphagia
[ ] Unspecified urinary incontinence	[ ] Feeling of incomplete bladder emptying	[ ] CVA
[ ] Mixed incontinence	[ ] Generalized Body Weakness	[ ] Debility
[ ] Overflow incontinence	[ ] Degenerative Osteoarthritis of_____	[ ] Paralysis
[ ] Other specified urinary incontinence	[ ] Autistic Disorder	[ ] Parkinson's disease
[ ] Incomplete defecation	[ ] Organic Brain Syndrome	[ ] 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: _____

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R x	PRODUCT DESCRIPTION	QUANTITY
	Hospital bed, semi-electric with rails and mattress.	1
	Powered pressure-reducing mattress overlay with pump.	1
	Patient lift, hydraulic include sling, straps.	1
	Commode Chair, Stationary w/fixed arms.	1

Height: 5'1'' Weight: 160 LB

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

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Insurance Name and ID.	Medicare:	Medicaid: 065816472
Other Insurance Name and ID : MERIDIAN HEALTH PLAN INC MMCP		

R x	PRODUCT DESCRIPTION	QUANTITY
	Skin protection wheelchair seat cushion	1

Height: 5'1'' Weight: 160 LB

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

DIAGNOSES:

[ ] Alzheimer's disease
[ ] Amputation of_____
[ ] Unsteady gait
[ ] Bronchial Asthma
[ ] Dysphagia
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R x	PRODUCT DESCRIPTION	QUANTITY
	Lightweight manual wheelchair with swing away 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: 160 LB

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

DIAGNOSES:

[ ] Alzheimer's disease
[ ] Amputation of_____
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DOCTOR'S INFORMATION

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

State of Illinois
Department of Healthcare and Family Services

HOSPITAL BED QUESTIONNAIRE

PATIENT INFORMATION

Name: Tyler, Ramona Recipient ID: 065816472

Diagnosis: _____ Height: 5'1" Weight: 160 lb

☒ Semi-Electric Hospital Bed ☐ Full Electric Hospital Bed

Does the patient have a caregiver? ☐ Yes ☐ No

Is the patient left alone for long periods of time? ☐ Yes ☐ No
If yes, how many hours per day? _____

Can the patient ambulate? ☐ Yes ☐ No

Is the patient bedridden? ☐ Yes ☐ No
If bedridden, what is the transfer method? _____

Is condition permanent? ☐ Yes ☐ No
If no, what is duration of need? _____

Can patient reposition self? ☐ Yes ☐ No

Is the patient able to operate controls on the hospital bed? ☐ Yes ☐ No

Does the patient require positioning not feasible in a standard bed? ☐ Yes ☐ No
If yes, explain: _____

Is this for post-op use? ☐ Yes ☐ No
If yes, date of surgery: _____

Prognosis: _____

Physician's signature: _____ Date: _____

Print Form

State of Illinois
Department of Healthcare and Family Services

Standard Manual Wheelchair Questionnaire

Participant's Name Tyler, Ramona RIN 065816472 Birth Date 08/18/1968

Height 5'1 Weight 160 lb Participant's Hip Width 16"

Procedure code and description of wheelchair
K0003 - Lightweight Manual Wheelchair

Weight capacity of wheelchair 300 lb 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

HFS 3701L (N-8-13)