Advanced Medical Supply, Inc

CLIENT/PATIENT VISIT REPORT

EQUIPMENT MAINTENANCE

info@advancedmedicalsupply.net
Phone: 773-205-6993 Fax:773-205-6994

Patient Name: Nelson -- Brown, Marisa Date: 03-18-24

Address: 2595 Harnish Dr Algonquin, IL 60102

Phone: 773-844-7437- Cell

EQUIPMENT INFORMATION

New Column SN#
SN-COLC-241025248

1. Item: Portable Oxygen system

HME: (Manufacturer): Inogen Model: One G5 Serial#: 22242768

Hours: 45MIN Setting(s): N/A

Next PM Due: Date________________ Hours:________________ PM Sticker Present: ☐Yes ☐No

Maintenance Performed: Warranty replacement of column pair.

☐ *EQUIPMENT EXCHANGE:*

*NewUnitModel:*________________ *SN:*________________ *Reason:*________________

☐ *EQUIPMENT D/C'd:*

*Reason*________________

PLAN OF SERVICE

Equipment functional? ☐ Yes ☐ No (If not, was it ☐ Repaired or ☐ Replaced?)

Client reeducated on the following? ☐ Use of Equipment ☐ Doctor's Prescription

☐ Emergency Preparedness ☐ Troubleshooting Equipment ☐ Fire / Electrical / Home Safety
☐ When to call for services ☐ Changes in Doctor's Orders ☐ Use of Back up Equipment

Comments:

93-08794-00-01-B, G5 Column Traveler

SN-COLC-241025248

Assembly: 20-08122-00-01
By: AL Date: 03-04-24

Zeolite Lot: M102891704-05

Alumina Lot: 013124

☑Arkema ☐ZeoChem	Weight (g)	P/F	Initial	Date	COMP
Column A	140	☑P	JM	03-04-24	JM
Column B	140	☐F			

Falls Assessment completed and reviewed? ☐ Yes ☐ No

Any falls hazards determined during assessment? ☐ Yes ☐ No, If Yes, Document concerns and information given the Client:________________

I acknowledge performance of the Client Visit and Plan of Service on the date noted:

Client: [signature] Date: 03-18-24 Technician: [signature]