

**Advanced Medical Supply, Inc**  
**CLIENT/PATIENT VISIT REPORT**  
**EQUIPMENT MAINTENANCE**  
**info@advancedmedicalsupply.net**  
**Phone: 773-205-6993 Fax: 773-205-6994**

Patient Name: Doody, Sandra

Date: 10-16-24

Address: 8975 W Golf Rd Apt 930 Niles, IL 60714

Phone: 847-470-8210- Michelle Dtr

Note: Call Dtr on your way. 2-5Pm

**EQUIPMENT INFORMATION**

1. Item: Semi-Electric Hospital bed with rails and mattress.

HME: (Manufacturer): Medline Model: MDR107002E Serial#: SED22124078

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

Next PM Due: Date \_\_\_\_\_ Hours: \_\_\_\_\_ PM Sticker Present: ☐ Yes ☐ No

Maintenance Performed: Move Hospital bed to Apt 509

☐ *EQUIPMENT EXCHANGE:*

New Unit Model: \_\_\_\_\_ 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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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: \_\_\_\_\_

Date: \_\_\_\_\_

Technician: \_\_\_\_\_

Advanced Medical Supply, Inc

3322 N. Milwaukee Ave.

Chicago, IL 60641

Phone: 773-205-6993

Fax: 773-205-6994

### Credit Card Authorization Form

Credit card type: Visa, Master Card, Discover (circle one)

Cardholder Name Doody Michelle Bloch

Credit Card Number 5254 7500 7667 3021

Expiration Date 06 / 27

CVS code 133

Billing Address Street \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip. 60053

I authorize Advanced Medical Supply to charge my credit card for the amount

\$ \$ 150.00

Cardholder Signature Phone Order

Date 10-16-24

ADVANCED MEDICAL SUP  
3322 N MILWAUKEE AVE  
CHICAGO, IL 60641  
773-205-6993

### Phone Order

xxxxxxxxxxxx3021

MASTERCARD

Entry Method: Manual

**Total: \$ 150.00**

10/16/24

10:53:24

Inv #: 000000001

Appr Code: 73771Z

Apprvd: Online

AVS Code: ZIP MATCH Z

CVV2 Code: MATCH M

Customer Copy

THANK YOU!