

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

PATIENT'S NAME: Gangl, Diana
DOB: 04/17/1951 HEALTH INSURANCE CLAIM No: 1C64H88DP86
ADDRESS: 5001 N Overhill Ave Norridge IL 60063

R x	PRODUCT DESCRIPTION	QUANTITY
	Respiratory suction pump, portable	1
	Tracheal suction catheter, 14Fr	90/Month
	Oropharyngeal suction catheter, yankauer	12/Month
	Connection tubing used w/suction pump	2/Month
	Canister, disposable used w/suction pump	2/Month

Refills: 12
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: _____