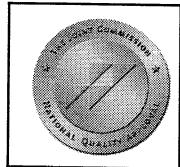


# **ADVANCED MEDICAL SUPPLY,**

## **INC**

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



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### FACSIMILE TRANSMITTAL SHEET

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|   |  |
|---|--|
| TO:   | FROM:                                  |
| DOCTOR: Dr. Satish Barnabas                       | Alex U.                                |
| PHONE: 773-561-4440                               | Fax: 773-205-6994                      |
| FAX:  | Phone: 773-205-6993                    |
| RE:   | DATE: 02-07-2025                       |
| PATIENT NAME:<br>TONYA RUSSELL<br>DOB: 06/05/1970 | TOTAL NO. OF PAGES INCLUDING<br>COVER: |

---

URGENT     FOR REVIEW     PLEASE COMMENT     PLEASE REPLY     PLEASE RECYCLE

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#### NOTES/COMMENTS:

There is an additional order for a CPAP machine. Plz, attach Sleep Studies.

*The patient requires a DME supplies . Please complete the necessary forms, attach, and fax them to me at 773-205-6994. If you have any questions, feel free to contact us at 773-205-6993.*

*Thank you very much for your cooperation.*

*Sincerely, Alex.*

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**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.

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

## DETAILED WRITTEN ORDER

PATIENT'S NAME: Russell, Tonya  
DOB: 06-05-1970 Insurance No: 070390133  
ADDRESS: 4235 Lindenwood Dr Apt 2B, Matteson, IL 60443

| R X | PRODUCT DESCRIPTION   | QUANTITY       |
|-----|---|----------------|
|     | Lightweight manual wheelchair<br>with swing away footrests, safety belt,<br>adjustable arm rest, heel holder-loops<br>and anti-tippers. | 1              |
|     | General use wheelchair seat cushion.  | 1              |
|     | General use wheelchair back cushion.  | 1              |
|     | Height: 4'6"  | Weight: 250 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 TONYA RUSSELL RIN 070390133 Birth Date 06/05/1970

Height 4'6" Weight 250 lb Participant's Hip Width 19"

Procedure code and description of wheelchair

K0003 - Lightweight Manual Wheelchair

Weight capacity of wheelchair 300 lb Width of wheelchair 20"

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)

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## DETAILED WRITTEN ORDER

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DOB: 06-05-1970 Insurance No: 070390133  
ADDRESS: 4235 Lindenwood Dr Apt 2B, Matteson, IL 60443

**R X**      **PRODUCT DESCRIPTION**      **QUANTITY**

Hospital Bed With Rails And Mattress                          1

Alternating Air Overlay Pad With Pump                          1

Height: 4'6"                          Weight: 250 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                   |
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### DOCTOR'S INFORMATION

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



## HOSPITAL BED QUESTIONNAIRE

### PATIENT INFORMATION

Name: TONYA RUSSELL

Recipient ID: 070390133

Diagnosis: \_\_\_\_\_

Height: 4'6"

Weight: 250 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](#)

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ADDRESS: 4235 Lindenwood Dr Apt 2B, Matteson, IL 60443

| R X | PRODUCT DESCRIPTION | QUANTITY |
|-----|---------------------|----------|
|-----|---------------------|----------|

|  |   |
|--|---|
| Shower Chair with back rest.               | 1 |
| Auto Blood pressure monitor with arm Cuff. | 1 |
| Gait Belt                                  | 1 |

Height: 4'6" Weight: 250 lb

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

### DIAGNOSES:

- |   |  |  |
|---|--|--|
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