ADVANCED MEDICAL SUPPLY, INC

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

FACSIMILE TRANSMITTAL SHEET

TO: Patel, Umang MD.	FROM: Alex U.
FAX NUMBER:. 630-910-6995	DATE:
RE: Rajendra Jain 05-08-1940	TOTAL NO. OF PAGES INCLUDING COVER: 2

☑ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☑ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

Please fill out attached forms then sent it back to me at 773-205-6994 - Fax

If you have any questions feel free to contact us at 773-205-6993.

Thank you very much for your cooperation.

Sincerely, Alex.

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.

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

WRITTEN DETAILED ORDER

PATIENT'S NAME: Rajendra Jain
DOB: 05/08/1940 **INSURANCE No:** 329558845
ADDRESS: 12009 Winterbury Ln, Plainfield, IL 60585

Rx

PRODUCT DESCRIPTION	QUANTITY
Rollator with seat, brakes and bucket.	1
Commode Chair, Stationary w/fixed arms	

Height: _____ Weight:_____ lbs

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

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

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: _____