

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

Patient Name: Richard Johnson

Date: 08-14-25

Address: 335 N Menard Ave Apt 414 Chicago IL 60644

Phone: 773-851-4243

EQUIPMENT INFORMATION

1. Item: Power wheelchair, Group 2, Captains chair

HME: (Manufacturer): Merits Model: P322 Serial#: TMU241200683

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

Battery Capacity: Left: 9.5; Right: 9.5

Maintenance Performed: Check Power wheelchair.

☐ *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?

- ☐ Emergency Preparedness
- ☐ When to call for services

- ☐ Use of Equipment
- ☐ Troubleshooting Equipment
- ☐ Changes in Doctor's Orders

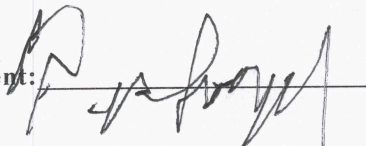
- ☐ Doctor's Prescription
- ☐ Fire / Electrical / Home Safety
- ☐ Use of Back up Equipment

Comments: Patient complaint power wheelchair don't hold charge.

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: 08/14/25

Technician: 