

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

DETAILED WRITTEN ORDER

Patient's Name:	SALOME J ZAMARRIPA		
Address:	5152 S HAMLIN AVE	City - State - Zip:	CHICAGO, IL 60632
Phone:	773-582-1565- Cell 708-737-6661		
DOB:	12/25/1960		
Insurance Name and ID.	Medicare:	Medicaid:359065588	
Other Insurance: MERIDIAN HEALTH PLAN INC MMCP			
R X	PRODUCT DESCRIPTION	QUANTITY	
Lightweight manual wheelchair with swing away footrests, safety belt, adjustable arm rest, heel holder-loops and anti-tippers.		1	
General use wheelchair seat cushion.		1	
General use wheelchair back cushion.		1	
Tub shower bench		1	
Height: 5'2"		Weight: 155 LB	
LENGTH OF NEED (# OF MONTHS): 99=LIFETIME			

DIAGNOSES:

- | | | |
|--|--|--|
| <input type="checkbox"/> Alzheimer's disease
<input type="checkbox"/> Amputation of _____
<input type="checkbox"/> Unsteady gait
<input type="checkbox"/> Bronchial Asthma
<input type="checkbox"/> Dysphagia
<input type="checkbox"/> Malnutrition
<input type="checkbox"/> Chronic Incontinence <input type="checkbox"/> Urine <input type="checkbox"/> Stool
<input type="checkbox"/> CVA
<input type="checkbox"/> CHF
<input type="checkbox"/> Degenerative Osteoarthritis of _____
<input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Dementia
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Emphysema/COPD/Asthma
<input type="checkbox"/> Fracture of _____
<input type="checkbox"/> Generalized Body Weakness
<input type="checkbox"/> Hernia (inguinal) (umbilical) (ventral)
<input type="checkbox"/> Organic Brain Syndrome
<input type="checkbox"/> Osteoporosis _____
<input type="checkbox"/> Paralysis
<input type="checkbox"/> Parkinson's disease
<input type="checkbox"/> Varicose Veins/ Venous Insufficiency | <input type="checkbox"/> Pendulous Abdomen
<input type="checkbox"/> Loss of Appetite
<input type="checkbox"/> Loss of Weight
<input type="checkbox"/> Renal Failure
<input type="checkbox"/> S/P CVA/Hemiparesis
<input type="checkbox"/> Carpal Tunnel Syndrome
<input type="checkbox"/> S/P Open Heart Surgery
<input type="checkbox"/> Debility
<input type="checkbox"/> Spondylosis (cervical) (lumbar)
<input type="checkbox"/> Sprain/Strain of _____
<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: _____
 Facility Name: _____ NPI#: _____
 Address: _____
 Phone: _____ Fax: _____



State of Illinois
Department of Healthcare and Family Services

Standard Manual Wheelchair Questionnaire

Participant's Name SALOME J ZAMARRIPA RIN 359065588 Birth Date 12/25/1960

Height 5'2" Weight 155 LB Participant's Hip Width 17"

Procedure code and description of wheelchair

K0003 - Lightweight Manual Wheelchair

Weight capacity of wheelchair 300 LB Width of wheelchair 18"

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 _____