

**Advanced Medical Supply, Inc**  
**CLIENT/PATIENT VISIT REPORT**  
**EQUIPMENT MAINTENANCE**  
**info@advancedmedicalsupply.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: 95; Right: 95

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?

Use of Equipment

Doctor's Prescription

Emergency Preparedness

Troubleshooting Equipment

Fire / Electrical / Home Safety

When to call for services

Changes in Doctor's Orders

Use of Back up Equipment

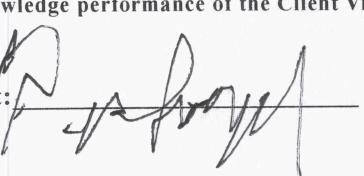
Comments: Patient complaint power wheelchair don't hold charge.

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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: 