

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

DETAILED WRITTEN ORDER

Patient's Name:	GUADALUPE RIVERA	
Address:	2343 N MANGO AVE FL2 CHICAGO, IL 60639	
Phone:	773-645-7234	
DOB:	01/19/1929	
Insurance Name and ID.	Medicare:	Medicaid: 190751735
Other Insurance Name and ID : MERIDIAN HEALTH PLAN INC MMCP		
R X		
PRODUCT DESCRIPTION		QUANTITY
Hospital Bed With Rails And Mattress		1
Alternating Air Overlay Pad With Pump		1
Patient Hoyer Lift With Sling And Straps		1
Tub Shower bench with back rest		1
Height: 5'8"		Weight: 154 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: _____ NPI#: _____
 Facility Name: _____
 Address: _____
 Phone: _____ Fax: _____



HOSPITAL BED QUESTIONNAIRE

PATIENT INFORMATION

Name: GUADALUPE RIVERA

Recipient ID: 190751735

Diagnosis:

Height: 5'8"

Weight: 154 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](#)