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

DETAILED WRITTEN ORDER

Patient's Name:	Vasquez Jose	
Address:	5544 S Karlov Ave Chicago IL 60629	
Phone:	773-831-0958- Son ; 312-813-7307-Dtr	
DOB:	03/31/1963	
Insurance Name and ID.	Medicare:	Medicaid: 151762556
Other Insurance: Meridian Medicaid		

R x	PRODUCT DESCRIPTION	QUANTITY
	Lightweight Wheelchair, 18 in. Width, 16 in. Depth – K0003	1
	Reclining Back, Full (Over 80 degrees) - E1226	
	Wheelchair Anti Tippers - E0971	
	Wheelchair Back Cushion, 18 in. Width - E2611	
	Wheelchair Seat Cushion, 18 in. Width - E2601	
	Wheelchair Brake Extenders - E0961	
	Elevating Legs Rests (ELRs) - K0195	
	Wheelchair Positioning Belt - E0978	
	Wheelchair Headrest Cushion - E0955	
	Wheelchair Heel Loops - E0951	
	Height Adjustable Wheelchair Arms, Standard - E0973	
	Adjustable Skin Protection Wheelchair Seat Cushion, 18 in. Width, Standard - E2622	
	Height: 5'3'' Weight: 110 LB	
	LENGTH OF NEED (# OF MONTHS): 99=LIFETIME	

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: _____

State of Illinois
Department of Healthcare and Family Services

Standard Manual Wheelchair Questionnaire

Participant's Name Vasquez Jose RIN 151762556 Birth Date 03/31/1963

Height 5'3" Weight 110 LB Participant's Hip Width 15"

Procedure code and description of wheelchair
K0003 - Reclainer Manual Wheelchair

Weight capacity of wheelchair 300 lb Width of wheelchair 16"

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