

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

## **DETAILED WRITTEN ORDER**

DETAILED WRITTEN ORDER			
Patient's Name:	GRECIA SALGADO		
Address:	4505 S WOOD ST FRNT 1FL CHICAGO, IL 60609		
Phone:	312-956-3149		
DOB:	12/06/1942		
Insurance Name and ID.	Medicare:	Medicaid:193981248	
Other Insurance: BCBS XOG911963068			
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
		3in1 Commode	1
		Height: 4'11"	Weight: 158 LB
LENGTH OF NEED (# OF MONTHS): 99=LIFETIME			

## DIAGNOSES:

- |  |   |                                     |
|--|---|-------------------------------------|
| [ ] Alzheimer's disease                  | [ ] Dementia                                | [ ] Pendulous Abdomen               |
| [ ] Amputation of _____                  | [ ] Dizziness                               | [ ] Loss of Appetite                |
| [ ] Unsteady gait                        | [ ] Emphysema/COPD/Asthma                   | [ ] Loss of Weight                  |
| [ ] Bronchial Asthma                     | [ ] Fracture of _____                       | [ ] Renal Failure                   |
| [ ] Dysphagia                            | [ ] Generalized Body Weakness               | [ ] S/P CVA/Hemiparesis             |
| [ ] Malnutrition                         | [ ] Hernia (inguinal) (umbilical) (ventral) | [ ] Carpal Tunnel Syndrome          |
| [ ] Chronic Incontinence                 | [ ] Organic Brain Syndrome                  | [ ] S/P Open Heart Surgery          |
| [ ] Urine                                | [ ] Osteoporosis _____                      | [ ] Debility                        |
| [ ] Stool                                | [ ] Paralysis                               | [ ] Spondylosis (cervical) (lumbar) |
| [ ] CVA                                  | [ ] Parkinson's disease                     | [ ] Sprain/Strain of _____          |
| [ ] CHF                                  | [ ] Varicose Veins/ Venous Insufficiency    | [ ] HTN                             |
| [ ] Degenerative Osteoarthritis of _____ |   |                                     |
| [ ] Diabetes Mellitus                    |   |                                     |

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: \_\_\_\_\_



## Standard Manual Wheelchair Questionnaire

Participant's Name GRECIA SALGADO RIN XOG911963068 Birth Date 12/06/1942

Height 4'11" Weight 158 LB Participant's Hip Width 16"

Procedure code and description of wheelchair

K0003 - Lightweight 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 \_\_\_\_\_