Advanced Medical Supply, Inc
CLIENT/PATIENT VISIT REPORT
EQUIPMENT MAINTENANCE

Client: Sandra, Doody Date: 1/09/2024

Address: 8975 W. Golf Rd. Apt. 930 Niles IL 60714

Phone: 847-942-5446 - Dtr - Michelle

EQUIPMENT INFORMATION

1. ITEM: Hospital Bed SER 2212407

HME: (Manufacturer) Medline Model: _____ Serial #: _____

Hours: _____ Setting(s): _____

Maintenance Performed: Move Hospital Bed From Room 509 - to Room 523

Next PM Due: Date _____ Hours: _____ PM Sticker Present: Yes No

2. ITEM _____

HME: (Manufacturer) _____ Model: _____ Serial #: _____

Hours: _____ Setting(s): _____

Maintenance Performed: _____

Next PM Due: Date _____ Hours: _____ PM Sticker Present: Yes No

EQUIPMENT EXCHANGES AND D/C'S

Old Unit _____ SN _____ New Unit _____ SN _____ Reason _____

Old Unit _____ SN _____ New Unit _____ SN _____ Reason _____

Old Unit _____ SN _____ New Unit _____ SN _____ Reason _____

D/C'd Unit _____ SN _____ Reason _____

D/C'd Unit _____ SN _____ Reason _____

PLAN OF SERVICE

Equipment functional? Yes No (If not, was it Repaired or Replaced?)

Client reeducated on the following?

- Emergency Preparedness
- When to call for services
- Use of Equipment
- Troubleshooting Equipment
- Changes in Doctor's Orders
- Doctor's Prescription
- Fire / Electrical / Home Safety
- Use of Back up Equipment

Comments:

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:

Michael Doody
Client

1/10/24
Date

Technician