

Advanced Medical Supply, Inc Tel: (773) 205-6993
EQUIPMENT MANAGEMENT ADMISSION ASSESSMENT AND PLAN OF SERVICE

CLIENT NAME _____

ADDRESS _____

PHONE _____

HOME ASSESSMENT/PATIENT ASSESSMENT

ARCHITECTURAL BARRIERS

SHELTER, HEAT, WATER, PLUMBING, REFRIGERATION, COOKING

ELECTRICAL (outlets should be ground, no use of extension cords)

FIRE SAFETY (smoking materials in home, working smoke detector, no potential for open flames)

FALLS ASSESSMENT COMPLETED AND CDC HANDOUTS REVIEWED?

ANY FALLS HAZARDS DETERMINED DURING ASSESSMENT?

IF YES, DOCUMENT CONCERNS AND INFORMATION GIVEN THE CLIENT: _____

- | | |
|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> ADEQUATE | <input type="checkbox"/> INADEQUATE |
| <input type="checkbox"/> ADEQUATE | <input type="checkbox"/> INADEQUATE |
| <input type="checkbox"/> ADEQUATE | <input type="checkbox"/> INADEQUATE |
| <input type="checkbox"/> ADEQUATE | <input type="checkbox"/> INADEQUATE |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO |

ANY OTHER SAFETY OR HEALTH HAZARDS? COMMENTS: _____

PATIENT INSTRUCTED WHEN INADEQUATE

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|------------------------------|-----------------------------|

PATIENT FUNCTIONALLY AND PHYSICALLY ABLE TO USE EQUIPMENT/SUPPLIES

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|------------------------------|-----------------------------|

PATIENT ABLE TO UNDERSTAND AND COMPREHEND INSTRUCTIONS

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|------------------------------|-----------------------------|

PATIENT IS SELF SUFFICIENT

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|------------------------------|-----------------------------|

PATIENT HAS WILLING CAREGIVER

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|------------------------------|-----------------------------|

EQUIPMENT INFORMATION

1. ITEM _____

Manufacturer: _____ Model: _____ Serial #: _____

Hours: _____ Setting(s): _____

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

2. ITEM _____

Manufacturer: _____ Model: _____ Serial #: _____

Hours: _____ Setting(s): _____

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

3. ITEM _____

Manufacturer: _____ Model: _____ Serial #: _____

Hours: _____ Setting(s): _____

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

PLAN OF SERVICE

Identified Needs/Problems: Expected Outcomes:

- The client will be provided prescribed equipment to comply with the physician's prescription.
- The client will use the home medical equipment as prescribed by the physician.
- The client will use and maintain home medical equipment in a safe/proper manner.
- The client will adhere to home safety guidelines.
- The client will be able to troubleshoot any equipment problems and/or use back-up system.
- The client will know how to obtain follow-up services as needed.

Services/Actions Provided:

- Deliver and set-up home medical equipment at a mutually agreed upon time and place.
- Provide training in safe/proper use and maintenance of all home medical equipment.
- Provide training and written handout in client rights and responsibilities, supplier standards, home safety, HIPPA Privacy standards, emergency planning and provide financial responsibilities
- Demonstrate troubleshooting of equipment and correct use of back-up system (if provided).
- Provide written instructions for use of the home medical equipment.
- Provide written instructions for obtaining routine/emergency follow-up services
- For equipment sold to the client the warranty card(s) are given to the client. Mark NA if no sale items are provided

I acknowledge training in the use of equipment and products provided and the performance of the Equipment Management Admission Assessment and Plan of Service on the date noted:

Client/Patient Signature

Date

Staff Member