

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

## DETAILED WRITTEN ORDER

Patient's Name: McCauley Ladweena  
DOB: 03/16/1968 Insurance No: XOG901522867  
Address: 9410 S Michigan Ave Chicago IL 60619

<b>R x</b>	<b>PRODUCT DESCRIPTION</b>	<b>QUANTITY</b>
	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

Height: 5'1''

Weight: 270 LB

**LENGTH OF NEED (# OF MONTHS): 99=LIFETIME**

### DIAGNOSES:

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



## Standard Manual Wheelchair Questionnaire

Participant's Name McCauley Ladweena RIN XOG901522867 Birth Date 03/16/1968

Height 5'1" Weight 270 LB Participant's Hip Width 17"

Procedure code and description of wheelchair  
K0003 - Lightweight Manual wheelchair

Weight capacity of wheelchair 350 LB Width of wheelchair 18"

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 \_\_\_\_\_