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	☐ ADEQUATE	☐ INADEQUATE
SHELTER, HEAT, WATER, PLUMBING, REFRIGERATION, COOKING	☐ ADEQUATE	☐ INADEQUATE
ELECTRICAL (outlets should be ground, no use of extension cords)	☐ ADEQUATE	☐ INADEQUATE
FIRE SAFETY (smoking materials in home, working smoke detector, no potential for open flames)	☐ ADEQUATE	☐ INADEQUATE
FALLS ASSESSMENT COMPLETED AND CDC HANDOUTS REVIEWED?	☐ YES	☐ NO
ANY FALLS HAZARDS DETERMINED DURING ASSESSMENT?	☐ YES	☐ NO

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

_____

ANY OTHER SAFETY OR HEALTH HAZARDS? COMMENTS:_____

PATIENT INSTRUCTED WHEN INADEQUATE	☐ YES	☐ NO
PATIENT FUNCTONALLY AND PHYSICALLY ABLE TO USE EQUIPMENT/SUPPLIES	☐ YES	☐ NO
PATIENT ABLE TO UNDERSTAND AND COMPREHEND INSTRUCTIONS	☐ YES	☐ NO
PATIENT IS SELF SUFFICIENT	☐ YES	☐ NO
PATIENT HAS WILLING CAREGIVER	☐ YES	☐ 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