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

DETAILED WRITTEN ORDER

Patient's Name:	Smith, Adrian	
Address:	3318 N Lake Shore DR apt 605 Chicago IL 60657	
Phone:	773-630-2909	
DOB:	02/08/1960	
Insurance Name and ID.	Medicare:	Medicaid: 960621167
Other Insurance Name and ID :		

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PRODUCT DESCRIPTION	QUANTITY
Pull ups/Diapers	200
Liners	120
Underpads	150
Gloves	200

Height: 5'9'' Weight: 170 LB

Refills: 11 Refills

DIAGNOSES:

[ ] Stress incontinence (female) (male)	[ ] Fecal smearing	[ ] Emphysema/COPD/Asthma
[ ] Urge incontinence	[ ] Fecal urgency	[ ] Dementia
[ ] Incontinence without sensory awareness	[ ] Full incontinence of feces	[ ] Diabetes Mellitus
[ ] Post-void dribbling	[ ] Drug induced retention of urine	[ ] Renal Failure
[ ] Nocturnal enuresis	[ ] Other retention of urine	[ ] CHF
[ ] Continuous leakage	[ ] Retention of urine, unspecified	[ ] Dysphagia
[ ] Unspecified urinary incontinence	[ ] Feeling of incomplete bladder emptying	[ ] CVA
[ ] Mixed incontinence	[ ] Generalized Body Weakness	[ ] Debility
[ ] Overflow incontinence	[ ] Degenerative Osteoarthritis of_____	[ ] Paralysis
[ ] Other specified urinary incontinence	[ ] Autistic Disorder	[ ] Parkinson's disease
[ ] Incomplete defecation	[ ] Organic Brain Syndrome	[ ] 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: _____