ADVANCED MEDICAL SUPPLY, INC

3322 N MILWAUKEE AVENUE
CHICAGO, IL 60641
PHONE: 773-205-6993
FAX: 773-205-6994

FACSIMILE TRANSMITTAL SHEET

TO: Allison L Curran NP/ Dr. Niraj Shah	FROM: Alex U.
PHONE: 815-726-2200	DATE:
FAX: 815-582-3253	10-25-24
RE: PATIENT NAME: Nasim Hafeez DOB: 12/1/1954	TOTAL NO. OF PAGES INCLUDING COVER: 2

☑ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☑ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

Please fill out the attached forms and most recent clinical, then send them back to me at 773-205-6994 - Fax

If you have any questions feel free to contact us at 773-205-6993.

Thank you very much for your cooperation.

Sincerely, Alex.

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

WRITTEN DETAILED ORDER

PATIENT NAME: Nasim Hafeez
DOB: 12/1/1954
ID #: 216136689
ADDRESS: 14440 Independence Drive, Plainfield, IL, 60544
PHONE: 815-507-3435

Rx

PRODUCT DESCRIPTION	QUANTITY
Rollator with seat, brakes and bucket.	**1**

Height: 5'4" Weight:160 lbs

LENGTH OF NEED (# OF MONTHS): 99=LIFTIME)

DIAGNOSES:

_____

_____

_____

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