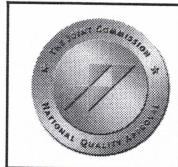


# **ADVANCED MEDICAL SUPPLY,**

## **INC**

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



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### FACSIMILE TRANSMITTAL SHEET

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TO: Khan, Aftab MD. FROM: Alex U.  
FAX NUMBER: 815-941-4105 DATE: 08-21-24  
RE: Davis, Jefferson 08-28-1960 TOTAL NO. OF PAGES INCLUDING COVER: 2

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URGENT    FOR REVIEW    PLEASE COMMENT    PLEASE REPLY    PLEASE RECYCLE

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NOTES/COMMENTS:

Please fill out attached forms then sent it 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.*

**THE INFORMATION CONTAINED IN THIS MESSAGE IS INTENDED ONLY FOR THE PROFESSIONAL AND CONFIDENTIAL USE OF THE DESIGNATED RECIPIENT(S).** This message and/or any attachments thereto may be confidential, legally privileged, and/or exempt from disclosure under applicable law. If the reader of this message is not an intended recipient, you are hereby notified that any review, use, disclosure, dissemination, forwarding or copying of this email message and/or attachments or taking of any action in reliance on the contents therein is strictly prohibited. Please notify Advanced Medical Supply, Inc immediately by telephone or fax, and destroy the message received in error. Thank you.

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

## DETAILED WRITTEN ORDER

**PATIENT'S NAME:** Davis, Jefferson  
**DOB: 08-28-1960** **HEALTH INSURANCE CLAIM No:** 096580154  
**ADDRESS:** 1305 Emington Ln Minooka, IL 60447

**Rx**

**PRODUCT DESCRIPTION**

**QUANTITY**

Shower chair with back

1

Height: 6'3"

Weight: 290 lbs

**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"/> Organic Brain Syndrome                  | <input type="checkbox"/> S/P Open Heart Surgery          |
| <input type="checkbox"/> Urine                                | <input type="checkbox"/> Osteoporosis _____                      | <input type="checkbox"/> Debility                        |
| <input type="checkbox"/> Stool                                | <input type="checkbox"/> Paralysis                               | <input type="checkbox"/> Spondylosis (cervical) (lumbar) |
| <input type="checkbox"/> CVA                                  | <input type="checkbox"/> Parkinson's disease                     | <input type="checkbox"/> Sprain/Strain of _____          |
| <input type="checkbox"/> CHF                                  | <input type="checkbox"/> Varicose Veins/ Venous Insufficiency    | <input type="checkbox"/> HTN                             |
| <input type="checkbox"/> Degenerative Osteoarthritis of _____ |  |  |
| <input type="checkbox"/> Diabetes Mellitus                    |  |  |

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: \_\_\_\_\_  
Facility Name: \_\_\_\_\_ NPI#: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_