Advanced Medical Supply, Inc

CLIENT/PATIENT VISIT REPORT

EQUIPMENT MAINTENANCE
info@advancedmedicalsupply.net
Phone: 773-205-6993 Fax:773-205-6994

Patient Name: Richard Johnson Date: 08-14-25

Address: 335 N Menard Ave Apt 414 Chicago IL 60644

Phone: 773-851-4243

EQUIPMENT INFORMATION

1. Item: Power wheelchair, Group 2, Captains chair

HME: (Manufacturer): Merits Model: P322 Serial#: TMU241200683

Hours: 45MIN Setting(s): N/A

Battery Capacity: Left: 9,5 ; Right: 9,5

Maintenance Performed: Check Power wheelchair.

□ *EQUIPMENT EXCHANGE:*

NewUnitModel: _____ *SN:* _____ *Reason* _____

□ *EQUIPMENT D/C'd:*

Reason _____

PLAN OF SERVICE

Equipment functional? □ **Yes** □ **No** **(If not, was it** □ **Repaired** **or** □ **Replaced?)**

Client reeducated on the following? □ **Use of Equipment** □ **Doctor's Prescription**

□ **Emergency Preparedness** □ **Troubleshooting Equipment** □ **Fire / Electrical / Home Safety**

□ **When to call for services** □ **Changes in Doctor's Orders** □ **Use of Back up Equipment**

Comments: Patient complaint power wheelchair don't hold charge.

Falls Assessment completed and reviewed? □ **Yes** □ **No**

Any falls hazards determined during assessment? □ **Yes** □ **No, If Yes, Document concerns and information given the Client:** _____

I acknowledge performance of the Client Visit and Plan of Service on the date noted:

Client: _____ **Date:** 08/14/25 **Technician:** _____