

**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	<input type="checkbox"/> ADEQUATE	<input type="checkbox"/> INADEQUATE
SHELTER, HEAT, WATER, PLUMBING, REFRIGERATION, COOKING	<input type="checkbox"/> ADEQUATE	<input type="checkbox"/> INADEQUATE
ELECTRICAL (outlets should be ground, no use of extension cords)	<input type="checkbox"/> ADEQUATE	<input type="checkbox"/> INADEQUATE
FIRE SAFETY (smoking materials in home, working smoke detector, no potential for open flames)	<input type="checkbox"/> ADEQUATE	<input type="checkbox"/> INADEQUATE
FALLS ASSESSMENT COMPLETED AND CDC HANDOUTS REVIEWED?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
ANY FALLS HAZARDS DETERMINED DURING ASSESSMENT?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
IF YES, DOCUMENT CONCERNS AND INFORMATION GIVEN THE CLIENT: _____		

ANY OTHER SAFETY OR HEALTH HAZARDS? COMMENTS: \_\_\_\_\_

PATIENT INSTRUCTED WHEN INADEQUATE	<input type="checkbox"/> YES	<input type="checkbox"/> NO
PATIENT FUNCTIONALLY AND PHYSICALLY ABLE TO USE EQUIPMENT/SUPPLIES	<input type="checkbox"/> YES	<input type="checkbox"/> NO
PATIENT ABLE TO UNDERSTAND AND COMPREHEND INSTRUCTIONS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
PATIENT IS SELF SUFFICIENT	<input type="checkbox"/> YES	<input type="checkbox"/> NO
PATIENT HAS WILLING CAREGIVER	<input type="checkbox"/> YES	<input type="checkbox"/> 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