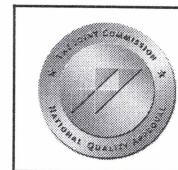


ADVANCED MEDICAL SUPPLY, **INC**

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



FACSIMILE TRANSMITTAL SHEET

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

☒ 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.

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.

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=LIFETIME)

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