

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

**DETAILED WRITTEN ORDER**

Patient's Name:	GUADALUPE RIVERA	
Address:	2343 N MANGO AVE FL2 CHICAGO, IL 60639	
Phone:	773-645-7234	
DOB:	01/19/1929	
Insurance Name and ID.	Medicare:	Medicaid: 190751735
Other Insurance Name and ID : MERIDIAN HEALTH PLAN INC MMCP		

**R x**

**PRODUCT DESCRIPTION**

**QUANTITY**

Hospital Bed With Rails And Mattress	1
Alternating Air Overlay Pad With Pump	1
Patient Hoyer Lift With Sling And Straps	1
Tub Shower bench with back rest	1

Height: 5'8"

Weight: 154 LB

**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: \_\_\_\_\_



## HOSPITAL BED QUESTIONNAIRE

### PATIENT INFORMATION

Name: GUADALUPE RIVERA

Recipient ID: 190751735

Diagnosis: \_\_\_\_\_

Height: 5'8"

Weight: 154 lb

☒ Semi-Electric Hospital Bed

☐ Full Electric Hospital Bed

Does the patient have a caregiver?

☐ Yes

☐ No

Is the patient left alone for long periods of time?

☐ Yes

☐ No

If yes, how many hours per day? \_\_\_\_\_

Can the patient ambulate?

☐ Yes

☐ No

Is the patient bedridden?

☐ Yes

☐ No

If bedridden, what is the transfer method? \_\_\_\_\_

Is condition permanent?

☐ Yes

☐ No

If no, what is duration of need? \_\_\_\_\_

Can patient reposition self?

☐ Yes

☐ No

Is the patient able to operate controls on the hospital bed?

☐ Yes

☐ No

Does the patient require positioning not feasible in a standard bed?

☐ Yes

☐ No

If yes, explain: \_\_\_\_\_

Is this for post-op use?

☐ Yes

☐ No

If yes, date of surgery: \_\_\_\_\_

Prognosis: \_\_\_\_\_

Physician's signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Form