

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

DETAILED WRITTEN ORDER

Patient's Name:	Wesley, Alexander		
Address:	184 W 147 th St Harvey IL 60626		
Phone:	331-341-7351		
DOB:	03-23-1972		
Insurance Name and ID.	Medicare:	Medicaid:	167633221
Other Insurance: Aetna better health MMCP			
R X	PRODUCT DESCRIPTION	QUANTITY	
	Lightweight manual wheelchair with swing away footrests, safety belt, adjustable arm rest, heel holder-loops and anti-tippers.	1	
	General use wheelchair seat cushion.	1	
	General use wheelchair back cushion.	1	
Height: 5'10"		Weight: 185 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"/> 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: _____ NPI#: _____
Facility Name: _____
Address _____
Phone: _____ Fax: _____



Standard Manual Wheelchair Questionnaire

Participant's Name Wesley, Alexander RIN 167633221 Birth Date 03/23/1972

Height 5'10" Weight 185 Participant's Hip Width 17"

Procedure code and description of wheelchair

K0003 - Lightweight Manual Wheelchair

Weight capacity of wheelchair 300 LB Width of wheelchair 18"

Diagnosis

Current ambulation status

Upper body control and strength

Does participant have the ability to self propel? Yes No

If not, why?

If the participant is unable to safely self-propel the manual wheelchair does he/she have a caregiver who is available, willing, and able to provide assistance with the wheelchair? Yes No

Does the participant need wheelchair to meet activities of daily living over the use of a walker or cane? Yes No

If not, why?

Is this being requested for temporary use for injury or post op? Yes No

If yes, date of injury or surgery _____ Expected duration of need _____

*All requests for renewal of post surgical/post injury wheelchairs will require updated MD script along with copy of MD clinical follow-up progress note.

Will this manual wheelchair meet participant's long term needs (3-5 years) or will participant need a customized wheelchair?

Physician's Name _____ Telephone Number _____

Attending Physician's Signature _____ Date Signed _____