Advanced Medical Supply, Inc
CLIENT/PATIENT VISIT REPORT
EQUIPMENT MAINTENANCE

Client: Puckett Arlene Date: 10-14-25

Address: 6645 S. Richmond St. Chicago, IL 60629

Phone: 773-593-6645

EQUIPMENT INFORMATION

1. ITEM: Semi-electric hospital bed

HME: (Manufacturer) Drive Model: 15548 Serial #: 1S19092521D

Hours: _____ Setting(s): N/A

Maintenance Performed: _____

Next PM Due: Date _____ Hours: _____ PM Sticker Present: ☐ Yes ☐ No

2. ITEM Air mattress.

HME: (Manufacturer) Proactive Model: 83500 Serial #: 19616916000S4

Hours: _____ Setting(s): N/A

Maintenance Performed: _____

Next PM Due: Date _____ Hours: _____ PM Sticker Present: ☐ Yes ☐ No

EQUIPMENT EXCHANGES AND D/C'S

Old Unit _____ SN _____ New Unit _____ SN _____ Reason _____

Old Unit _____ SN _____ New Unit _____ SN _____ Reason _____

Old Unit _____ SN _____ New Unit _____ SN _____ Reason _____

D/C'd Unit _____ SN _____ Reason _____

D/C'd Unit _____ SN _____ Reason _____

PLAN OF SERVICE

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

Client reeducated on the following?

☐ Emergency Preparedness ☐ Use of Equipment ☐ Doctor's Prescription
☐ When to call for services ☐ Troubleshooting Equipment ☐ Fire / Electrical / Home Safety
☐ Changes in Doctor's Orders ☐ Use of Back up Equipment

Comments: No air is in middle rolls of mattress

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:

Arlene Puckett — Client

10/16/25 — Date

[signature] — Technician