Health Equipment Loan Program – Short Term Loan Referral Form – B.C.

NOTE: Equipment substitutions (including size) must be approved by your Health Care Professional
Please contact your local Red Cross to confirm equipment availability
Fax form to:_____

INCOMPLETE FORMS CANNOT BE PROCESSED. Please fill out this form in its entirety, INCLUDING THE INFORMATION RELEASE.

Client: Personal health number: _____ ☐ Palliative

Last name: _____ First name: _____ Phone: _____

Birthdate (DD/MM/YYYY): _____ Gender: M / F **Height (cm/ft):** _____**Weight (kg/lb):** _____
Height / weight is critical to ensure client is provided with suitable, safe equipment

Address: _____ City: _____ Province: _____

Postal code: _____ Family Doctor: _____ Phone Number: _____

Alternate Contact: Name: _____ Alternate Phone Number: _____ Relationship: _____

Information Release - REQUIRED

I authorize my Health Care Professional, the Red Cross Health Equipment Loan Program and its representatives to release or obtain from such agencies, individuals, medical centres or hospitals any and all pertinent information which may be necessary to assist in the loan of medical equipment to me. **I consent to the collection, use, and disclosure of my personal information for this purpose, in accordance with the Canadian Red Cross Privacy Policy at www.redcross.ca, until I notify you otherwise.** I understand I may withdraw my consent by contacting privacy@redcross.ca.

CHOOSE ONE: ☐ I am the client and I consent to the above paragraph
☐ I am the client's Health Care Professional and I have obtained my client's consent to the above paragraph

Date: _____ Print Name: _____ Signature: _____

BATHROOM

Adjustable Bath Chair
☐ Back or ☐ No Back

Bath Board
☐ Flush

Bath Transfer Bench
☐ Arm on Right or ☐ Arm on Left
☐ Padded or ☐ Plastic
☐ Tall Tub Wall
Outside Height: ___inches

Bathtub Safety Rail
☐ Clamp On

Commode
Seat to Floor Height: ___inches
☐ Stationary ☐ Wheeled
☐ Shower

Raised Toilet Seat, Round (Clamp on)
☐ 2" ☐ 4" ☐ 5"/6"
☐ w/ arms ☐ w/out arms
☐ **Elongated Toilet Seat Elevator (w/out arms)**
☐ **Toilet Safety Frame**

WALKING AIDS

Frame Walker
Handgrip to Floor Height: ____inches
☐ No Wheels or ☐ Two Wheels
☐ Pediatric* ☐ Wide
☐ Glide Caps/Skis (recommended for carpet)
☐ Gutter Attachment*
Gutter to Floor Height: _____inches
☐ Left ☐ Right ☐Both

Side/Hemi Walker
☐ Handgrip to Floor Height: ___inches

Four Wheeled Walker
Handgrip to Floor Height: _____inches
Seat to Floor Height: _____inches
☐ Standard ☐ Wide

Crutches
Crutch Height: _____ inches
☐ Axilla ☐ Pediatric*
☐ Gutter Attachment *
Gutter to Floor Height: _____inches
☐ Left ☐ Right ☐Both
☐ Forearm—Handgrip Height:
_____inches

WALKING AIDS

Cane
Cane Height: _____inches
☐ Single ☐ Pair

Quad Cane
Cane Height: _____inches
☐ Right Side ☐ Left Side
☐ Small Base ☐ Large Base

WHEELCHAIRS

☐ Self propelled ☐ Pediatric*
☐ Transport ☐ Reclining
(All chairs come with footrests)
Seat Width:
☐12" ☐14" ☐16" ☐18" ☐20"*
☐22"* ☐24"*
Seat Depth:
☐12" ☐14" ☐16" ☐18"
Seat to Floor Height:
☐ Standard ☐ Hemi (17.5" or lower)
Elevating Leg Rests:
☐Right ☐ Left ☐ Both

Foam Cushion
☐16"x 16" ☐18" x 16" ☐18" x 18"

OTHER: ☐ Bed Assist ☐ IV Pole ☐ Bed Cradle

Referral Date (DD/MM/YYYY): _____ **Referring Health Care Professional:** Full Name: _____

Signature: _____ Phone Number: _____

Professional Designation (circle one): RN / OT / PT / DR / Other (specify): _____

Place of Work: _____ Anticipated Length of Loan: 1___ 2___ 3___ 4___ 5___ 6___month(s)

Additional Information:_____