Health Equipment Loan Program – Referral Form – Alberta

NOTE: Equipment changes or substitutions must be approved by your Health Care Professional
Please contact your local Red Cross to confirm equipment availability

Email: ABHELPprogram@redcross.ca **Fax form to:**____________________

Client: Last name: ______________________ First name: ______________ Phone: ______________

Birthyear (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: ____________ Phone Number: ______________ Referral Date: _____________________

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

Bathtub Safety Rail
☐ Clamp On

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

Raised Toilet Seat, Round (Clamp on)
☐ 2” ☐ 4” ☐ 5”/6” round
☐ Left cut out ☐Right cut out
☐ 5” Round seat with arms

☐3.5”Elongated Toilet Seat Elevator (w/out arms)

☐3.5” elongated with arms

☐ Toilet Safety Frame

WALKING AIDS

Frame Walker
Handgrip to Floor Height: ____inches
☐ No Wheels or ☐ Two Wheels
☐ 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*
☐ Reclining
(All chairs come with footrests)
Seat Width:
☐12” ☐14” ☐16” ☐18” ☐20”*
☐22”* ☐24”*

Transport
☐15” ☐17” ☐19” ☐22”
Seat to Floor Height:
☐ Standard ☐ Hemi (17.5” or lower)
Elevating Leg Rests:
☐Right ☐ Left ☐ Both

OTHER: ☐ Bed Assist ☐ IV Pole ☐ Bed Cradle ☐ Overbed Table

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 _______ Surgery Date______________ ☐ Discharge ☐ Palliative