



# Health Equipment Loan Program - Short Term Loan Extension Request

Note: Loan extensions may only be granted up to an additional 3 months

Fax form to: \_\_\_\_\_

[www.redcross.ca/help](http://www.redcross.ca/help)

Please fill out this form in its entirety. Incomplete forms cannot be processed.

**Client:** Personal health number: \_\_\_\_\_

Last name: \_\_\_\_\_ First name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Birthdate (DD/MM/YYYY): \_\_\_\_\_ Gender: M / F

Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_

### The following to be completed by an approved registered Health Care Professional

Please extend the equipment below for:  1 month  2 months  3 months

What equipment is being extended:

**To be eligible for an extension of the equipment loaned from the Red Cross Basic Loan Program, the following criteria must be met:**

The absence of equipment poses a significant risk of injury to the caregiver or client

AND (select one of the options below):

Client requires equipment for up to 3 additional months to recover from injury

Client has purchased the equipment and is waiting for its arrival within the next 3 months

Anticipated arrival date: \_\_\_\_\_

Client has been approved for equipment by another organization/program and is waiting for its arrival within the next 3 months

Funding Organization name: \_\_\_\_\_ When equipment is expected: \_\_\_\_\_

Date referral initiated: \_\_\_\_\_

Client is wait-listed for a facility

Date facility process was initiated: \_\_\_\_\_ Estimated time before placement: \_\_\_\_\_

Client is registered with BC Palliative Care Benefits Program

**I, the above client's HCP, have reviewed the equipment and the length of loan with the above client. The client understands that this is a short term loan and the equipment must be returned at the end of the extension period indicated above.**

**Health Care Professional (HCP) Name:** \_\_\_\_\_ **Designation:** \_\_\_\_\_

**HCP Phone Number:** \_\_\_\_\_

**Date (DD/MM/YYYY):** \_\_\_\_\_