



**Health Equipment Loan Program - Referral Form - Alberta**

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

Fax form to: \_\_\_\_\_  
[www.redcross.ca/help](http://www.redcross.ca/help)

**Client:** Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Birthyear (YYYY): \_\_\_\_\_ Gender: M / F Height (cm/in): \_\_\_\_\_ Weight (kg/lb): \_\_\_\_\_  
*Height / weight is critical to ensure client is provided with suitable, safe equipment*  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_  
 Postal code: \_\_\_\_\_ Personal health number: \_\_\_\_\_  
 Alternate Contact: Name: \_\_\_\_\_ Alternate Phone Number: \_\_\_\_\_

<p><b>Adjustable Bath Chair</b>  <input type="checkbox"/> Back <u>or</u> <input type="checkbox"/> No Back  <b>Bath Board</b>  <input type="checkbox"/> Flush  <b>Bath Transfer Bench</b>  <input type="checkbox"/> Arm on Right <input type="checkbox"/> Arm on Left  <input type="checkbox"/> Padded <u>or</u> <input type="checkbox"/> Plastic  <b>Bathtub Safety Rail</b>  <input type="checkbox"/> Clamp On <u>or</u> <input type="checkbox"/> Suction            Other _____</p>	<p><b>Frame Walker</b>          Handgrip to Floor Height: _____ inches  <input type="checkbox"/> Two Wheels <u>or</u> <input type="checkbox"/> No Wheels  <input type="checkbox"/> Pediatric <input type="checkbox"/> Wide  <input type="checkbox"/> Glide Caps/Skis (recommended for carpet)  <b>Gutter Attachment</b>          Gutter to Floor Height: _____ inches  <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both  <input type="checkbox"/> <b>Walker Tray</b>  <input type="checkbox"/> <b>Side/Hemi Walker</b>          Handgrip to Floor Height: _____ inches</p>	<p><b>Wheelchair</b>  <input type="checkbox"/> Self propelled <input type="checkbox"/> Pediatric  <input type="checkbox"/> Transport <input type="checkbox"/> Reclining          Seat Width:  <input type="checkbox"/> 12" <input type="checkbox"/> 14" <input type="checkbox"/> 16" <input type="checkbox"/> 18" <input type="checkbox"/> 20"  <input type="checkbox"/> 22" <input type="checkbox"/> 24"          Seat-to-Floor Height:  <input type="checkbox"/> Standard (19") <input type="checkbox"/> Hemi (17.5")          (All chairs come with footrests)  <b>Elevating Leg Rests</b>  <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both  <input type="checkbox"/> <b>Seat belt</b>          Other: _____</p>
<p><b>Commode</b>  <input type="checkbox"/> Stationary <input type="checkbox"/> Pediatric  <input type="checkbox"/> Wheeled <input type="checkbox"/> Shower            Other: _____</p>	<p><b>Four Wheeled Walker</b>          Seat to Floor Height: _____ inches          Handgrip to Floor Height: _____ inches  <input type="checkbox"/> Standard <input type="checkbox"/> Wide  <input type="checkbox"/> Basket <input type="checkbox"/> Tray            Other: _____</p>	<p><b>Cane</b>          Cane Height: _____ inches  <input type="checkbox"/> Single <input type="checkbox"/> Pair  <b>Quad Cane</b>  <input type="checkbox"/> Right Side <input type="checkbox"/> Left Side  <input type="checkbox"/> Small Base <input type="checkbox"/> Large Base</p>
<p><b>Raised Toilet Seat</b>  <input type="checkbox"/> 2" <input type="checkbox"/> 4" <input type="checkbox"/> 5"/6"  <input type="checkbox"/> Left Cut Out <input type="checkbox"/> Right Cut Out  <input type="checkbox"/> Clamp On <input type="checkbox"/> No Clamp  <input type="checkbox"/> 5" With Attached Arm Rests  <input type="checkbox"/> Elongated toilet seat elevator  <input type="checkbox"/> <b>Toilet Safety Frame</b></p>	<p><b>Crutches</b>          Crutch Height: _____ inches  <input type="checkbox"/> Axilla <input type="checkbox"/> Pediatric  <input type="checkbox"/> Forearm          Hand grip Height: _____ inches  <b>Gutter Attachment</b>          Gutter-Floor Height: _____ inches  <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both</p>	<p><b>Other</b>  <input type="checkbox"/> Bed Assist  <input type="checkbox"/> IV Pole  <input type="checkbox"/> Bed Cradle  <input type="checkbox"/> Overbed Table</p>

**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: \_\_\_\_\_ Referral Date: MM-DD-YY \_\_\_\_\_