



**CANADIAN
RED CROSS
CROIX-ROUGE
CANADIENNE**

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

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

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: _____

Adjustable Bath Chair

☐ Back or ☐ No Back

Bath Board

☐ Flush

Bath Transfer Bench

☐ Arm on Right ☐ Arm on Left

☐ Padded or ☐ Plastic

Bathtub Safety Rail

☐ Clamp On or ☐ Suction

Other _____

Frame Walker

Handgrip to Floor Height: _____ inches

☐ Two Wheels or ☐ No Wheels

☐ Pediatric ☐ Wide

☐ Glide Caps/Skis (recommended for carpet)

Gutter Attachment

Gutter to Floor Height: _____ inches

☐ Left ☐ Right ☐ Both

Walker Tray

☐ Side/Hemi Walker

Handgrip to Floor Height: _____ inches

Wheelchair

☐ Self propelled ☐ Pediatric

☐ Transport ☐ Reclining

Seat Width:

☐ 12" ☐ 14" ☐ 16" ☐ 18" ☐ 20"

☐ 22" ☐ 24"

Seat-to-Floor Height:

☐ Standard (19") ☐ Hemi (17.5")

(All chairs come with footrests)

Elevating Leg Rests

☐ Right ☐ Left ☐ Both

☐ Seat belt

Other: _____

Commode

☐ Stationary ☐ Pediatric

☐ Wheeled ☐ Shower

Other: _____

Four Wheeled Walker

Seat to Floor Height: _____ inches

Handgrip to Floor Height: _____ inches

☐ Standard ☐ Wide

☐ Basket ☐ Tray

Other: _____

Cane

Cane Height: _____ inches

☐ Single ☐ Pair

Quad Cane

☐ Right Side ☐ Left Side

☐ Small Base ☐ Large Base

Raised Toilet Seat

☐ 2" ☐ 4" ☐ 5"/6"

☐ Left Cut Out ☐ Right Cut Out

☐ Clamp On ☐ No Clamp

☐ 5" With Attached Arm Rests

☐ Elongated toilet seat elevator

☐ Toilet Safety Frame

Crutches

Crutch Height: _____ inches

☐ Axilla ☐ Pediatric

☐ Forearm

Hand grip Height: _____ inches

Gutter Attachment

Gutter-Floor Height: _____ inches

☐ Left ☐ Right ☐ Both

Other

☐ Bed Assist

☐ IV Pole

☐ Bed Cradle

☐ Overbed Table

Foam Cushion (not avail. in all sites)

☐ 16" x 16" ☐ 18" x 16" ☐ 18" x 18"

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 _____