Health Equipment Loan Program (H.E.L.P) – Bed Loan Referral Form – P.E.

NOTE: Equipment substitutions must be approved by your Health Care Professional.

One e-mail: peihelp@redcross.ca for all the referrals across the province. www.redcross.ca/help

Charlottetown Office
29 Paramount Drive, Charlottetown
Phone: 902-628-6262
e-mail peihelp@redcross.ca

Summerside Office
10 Slemon Park Dr., Summerside
Phone: 902-724-2724
e-mail peihelp@redcross.ca

Client: Last name:__________________________________ **First name:** _______________________________________

Address:____ **City:** ________________________ **Province:**___________

Postal code:__________________ **Phone Number:**______________________ Personal health number:_____________

Birth date: (dd/mm/yyyy) Gender:_______ Height (cm/in): _________ Weight (kg/lb): ________

Bed type: General bed ___ / Palliative bed___. ***Height / weight is critical to ensure client is provided with suitable, safe equipment.***

Alternate Contact: Name:__________________________________**Alternate Phone Number:**_____________________

The Canadian Red Cross Bed Loan will support recovery at home following an injury or illness. The loan referral is made to the Canadian Red Cross and must be completed by a qualified health professional. The loan is for short term recovery and is intended for a three month period with a maximum of six months. If the bed is needed longer, please let the local Canadian Red Cross office know in advance of the scheduled return date to extend the bed loan. A technician will deliver and set up the bed and when it is no longer required, will remove the bed from the home.

To qualify for the RC Bed Loan Program:

☐ I am 18 Years of age
☐ I am a resident of Prince Edward Island
☐ I carry a valid PEI Health Card
☐ I understand the service is provided on a first-come, first-serve basis and I may be put on a waiting list for a requested type of bed to become avalible.
☐ I understand I will be contracted by Canadian Red Cross – PEI to collect additional required information.
☐ I understand that this referral needs to be completed and signed by a health care provider.

Please note that unless stated otherwise the bed provided is a standard Home Care electric hospital bed

Referring Health Care Professional: Full Name: ____

Signature: _____________________________________ Phone Number: ____________________________

Professional Designation (circle one): MD / NP / RN / LPN / PT / OT / RSW / DC

Place of Work: ______________________________________ Anticipated Length of Loan: 1___ 2___ 3___ month(s)

Additional Information:____ Referral Date: (dd/mm/yyyy)