



Health Equipment Loan Program Short Term Loan Referral Form

Northern Health Connection Bus required _____

Client Name: First _____ Last _____ Date: _____

Address: _____ # _____

City: _____ Postal Code: _____

Phone #: _____ Height: _____ *Weight: _____

Date of Birth: _____ Sex: M / F Alternate Contact: Name _____ ph # _____

Name of referring Health Care Provider: _____ Signature: _____
(For follow-up)

Professional designation (circle one) RN / OT / PT / DR Other: _____ Phone # _____

Length of loan 1 ___ /2 ___ /3 ___ month(s) ___ (max 6 months)

MANUAL WHEELCHAIR

Seat width _____ inches
 Seat depth _____ *Standard depth is 16"*
 Child's 12"x12" _____ 14"x14" _____
 Transport chair _____ inches
 Removable arms Y N no preference
 Hemi height (17.5") Y N no preference
 Elevating leg rests Y N no preference

Specifics: _____

TOILETTING AIDS

Raised Toilet Seat
 clamp on bubble with arms (5" only)
 Standard 5" 2" 4"
 Cut out: Left (5") _____ Right (5") _____
 Toilet safety frame
 Commode
 wheeled stationary drop arm

BATH AIDS

Bath tub transfer bench
 Handle on right left either
 Bath chair back no back
 Bath board flush raised
 Tub grab bar clamp suction

AIDS TO DAILY LIVING

Reacher Sock Aid
 Long handled shoe horn Bed Cradle

WALKING AIDS

Walker - Standard No wheels Standard Two wheels
 4 wheel walker- Indicate seat height from floor:
 19-20 " _____ 21- 22" _____ 23- 24 " _____
 250 lb* _____ 350 lb* _____ 400 lb* _____
 Slow-down brakes _____ Basket _____
 Height of handle from floor _____ inches
 Cane height from floor _____ inches
 Quad cane small base large base
 Height from floor _____ inches
 Crutches Ice picks

OTHER

Bed assist handle Arco bed rail Smart Rail
 IV pole Bed Cradle Overbed table

***Please indicate client weight to ensure proper equipment is loaned**

Form Revised April 2010
http://www.redcross.ca/cmslib/general/nbcy_basic_referral_form091120.pdf