



Health Equipment Loan Program Short Term Loan Referral Form



Fax form to:

Client Name: _____ Date of Referral: _____

Address: _____ # _____

City: _____ Postal Code: _____

Phone: _____ Height: _____ Weight: _____

Date of Birth: _____ Sex: M / F

Name of referring health professional: _____ Phone: _____ (for follow-up if nec.)

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

Length of loan 1 ___ /2___ /3___ Month(s) (maximum 3 months)

MANUAL WHEELCHAIR

Seat width _____ inches

Seat depth _____ *Standard depth is 16"*

Child's 12"x12" _____ 14"x14" _____

Transport chair _____

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)

Height from toilet: 2" 4" 5"

Toilet safety frame

Commode

wheeled stationary drop arm

BATH AIDS

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

Standard walker Two wheels No wheels

4 wheel walker Seat height from floor _____ inches

Height of handle from floor _____ inches

Cane Height from floor _____ inches

Quad cane small base large base

Height from floor _____ inches

Crutches Height from floor _____ inches

Ice picks

OTHER

Bed assist handle Arco bed rail Smart Rail

IV pole Bed Cradle Overbed table

* Standard weight capacity is 250 lb