



Health Equipment Loan Program (HELP)
 1399 Sixth Avenue
 Prince George, BC V2L 5L6
 HELP Ph: 250-564-6567 Fax: 250-564-6577
 Toll Free: 1-800-278-7177

Hours: Mon-Fri-- 8:30 am - 4:30 pm
 To view available equipment visit:
www.redcrossequipment.com

Date of Referral: _____

Date equipment is required: _____

Length of Loan Period:
 (Maximum 3 months) 1 ___ / 2 ___ / 3 ___ Month(s)

Installation Required: Yes / No

Delivery/Installation Fee Billed to: Client ___ NHA ___

Fee: \$100 Hospital Bed, \$50 per hour for Bariatric Bed.
 All other equipment \$ 50. Mileage applies to outside PG city limits.
 Fee includes delivery, installation and pick-up.
 Northern Health Connections Bus required _____

Referral Form for Enhanced Equipment (Page 1) and Basic Equipment (Page 2)

Client Information

Name: _____

Address: _____

City: _____

Phone Number: _____

Weight _____ Height _____

Alternate Contact: Name _____ # _____

Health Care Provider Information

Name: _____

Designation: _____

Phone Number: _____

Signature: _____

Hospital Bed
 * Requires installation by Red Cross

Fully Electric with care guard Mattress and half rails
 250 lb* _____ 425 lbs* _____ (** extra fee)

Action Gel Overlay Mattress: (35" x 80") _____

Floor to Ceiling Pole with side arms
 * Requires installation by Red Cross Sketch of pole location:

Ceiling Height:
 7 feet _____
 8 feet _____
 9 feet _____

Tilt in Space Wheelchair / Enhanced Cushions
 * Therapist needs to contact Red Cross Technician prior to loan – to ensure suitability for client.

Adult Size:(width x depth) _____ x _____

Roho Cushions: High profile _____ Low profile _____

10 x 10 (18" x 18") _____ 9 x 10 (16" x 18") _____ 10x11 _____

Action Gel Cushion 18" x 18" _____

Other Enhanced Equipment:

Bath Lift Battery Operated _____

Transfer Disk (Row Medic) _____ Beazy Board _____

Gutter Walker _____ left _____ right _____ wheels

Other: _____

I understand that the equipment is due back on the loan record due date. I accept full responsibility for any loss or damage to the equipment and I agree to report any problems to Canadian Red Cross promptly. I acknowledge that such equipment is loaned on an 'as is' basis and that by accepting the loan of such equipment, I waive my right to any claim against the Canadian Red Cross concerning the condition, quality, durability, suitability, fitness or operation of such equipment. I consent to the collection, use and disclosure of the personal information provided above in accordance with the Canadian Red cross Privacy Policy, available at this office and at www.redcross.ca , until I notify you otherwise.

Client Signature: _____ *Form Revised on November 2009*



EQUIPMENT REQUEST FORM – Basic Equipment Page 2

<p>Bath Seat</p> <p>Back _____ No back _____</p> <p>250 lb* _____ 400 lb* _____</p>	<p>Tub Grab Bar</p> <p>Clamp on _____ Suction _____</p> <p>Fiberglass tub _____ Porcelain tub _____</p> <p>Extra wide tub edge (6") _____</p>	<p>Bath Boards</p> <p>Regular Bath Board _____</p> <p>330lb * _____</p>
<p>Bath Transfer Bench</p> <p>Left handle _____ Right handle _____</p> <p>Reversible _____</p> <p>(right and left refers to handle placement while sitting on bench)</p> <p>250 lb* _____ 400 lb* _____</p>	<p>Commode</p> <p>Stationary _____ Wheeled _____</p> <p>With drop arms _____</p> <p>450 lb* Stationary _____</p> <p>850 lb* Stationary _____</p> <p>Shower Commode Chair with Tilt _____</p>	<p>Toilet Safety Products</p> <p>Toilet Safety Frame _____</p> <p>Raised Toilet Seat (2") _____ (5") _____</p> <p>With arms _____ No arms _____</p> <p>Clamp On (adjustable 2" - 5") _____</p> <p>415 lb*(2") _____ 415 lb*(5") _____</p> <p>Cut out: Left (5") _____ Right (5") _____</p>
<p>Cane</p> <p>Cane Height _____ (inches)</p> <p>550 lb Capacity _____</p> <p>Single _____ Pair _____</p> <p>Quad Cane _____</p> <p>Cane height _____ (inches)</p> <p>Right side _____ Left side _____</p> <p>Narrow base _____ Wide base _____</p> <p>Side Stepper _____ Ice Pick (s) _____</p> <hr/> <p>Crutches</p> <p>Under 4'6" _____</p> <p>4'6" - 5'2" _____</p> <p>5'2" - 5'10" _____</p> <p>5'10" - 6'6" _____</p> <p>5'2" - 5'10" 550 lb* Capacity _____</p> <p>Forearm crutches _____ Ice Pick (s) _____</p> <p>Misc Equipment :</p> <p>Reacher _____ Sock Aid _____</p> <p>Bed Cradle _____ Shoe Horn _____</p>	<p>Wheelchair</p> <p>Child Size:</p> <p>12"x12" _____ (165 lb* Capacity)</p> <p>14"x14" _____</p> <p>Adult size:</p> <p><i>Width: Depth: Height from floor:</i></p> <p>16" x _____ _____ _____</p> <p>18" x _____ _____ _____</p> <p>20" x _____ _____ _____</p> <p>20" x 18" (350 lb*) _____ _____</p> <p>22" x 18" (450 lb*) _____ _____</p> <p>Transporter Chair _____</p> <p>Foam Cushion _____</p> <p>Footrests:</p> <p>Standard _____ Elevating _____</p> <p>Folding Wheelchair Ramps</p> <p>7 ft _____ 10 ft _____</p> <hr/> <p>Please indicate any other special requirements: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Walker</p> <p>Adult _____ Child (3 ft 4" to 4 ft) _____</p> <p>Standard _____ Small _____ Tall _____</p> <p>No Wheels _____ 2 Wheels _____</p> <p>300 lb* _____ 400 lb* _____ 700 lbs* _____</p> <p>Narrow (17" width) _____</p> <hr/> <p>4-Wheeled Walker</p> <p>Specify seat heights from floor</p> <p>19-20 " _____ 21- 22" _____ 23- 24 " _____</p> <p>250 lb* _____ 350 lb* _____ 400 lb* _____</p> <p>Specify handle height from floor _____"</p> <p>Slow-down brakes _____ Basket _____</p> <hr/> <p>Bed Rails</p> <p>Smart rail _____ Arco bed rail _____</p> <p>Bed Assist Handle _____</p>

*Indicates maximum weight capacity. Standard weight capacity is 250 lbs unless otherwise noted.

NOTE: Form must be signed by Client and Health Care Provider

Form Revised November 2009