CANADIAN RED CROSS

Health Equipment Loan Program

HELP *Plus* Referral Form

Victoria office | 909 Fairfield Rd | Fax: 250-382-3449
Nanaimo office | #3 – 2525 McCullough Rd | Fax: 250-756-9362

STEP 1: Therapist Information

Today's Date:	Therapist Name:	Phone:
☐ Obtained informed consent from client to submit this request by fax		
Therapist Designation:	Therapist Signature:	
Therapist Workplace:		

STEP 2: Equipment is for:

☐ Pickup at Red Cross
☐ Delivery to client - Select Payment Type: ☐ Client ☐ Invoice Client ☐ VIHA (all palliative clients)

STEP 3: Client information ☐ PALLIATIVE (client is registered with B.C. Palliative Benefits)

Name:	Phone:	
Address:		Postal Code:
Alternate Contact Name:	Phone:	
Weight: lbs/Kg	Height: inches/meters	Smoker: ☐ Yes ☐ No

STEP 4:

☐ Raised Toilet Seat (circle one) 2" / 4" / 6"
☐ 2 wheel walker height: _____ in/cm
☐ Bathtub Safety Rail
☐ Bath Transfer Bench (circle one) Taps L or R
☐ Bed Assist Handle
☐ Hospital Bed – Rails (circle one) None or Half or Full
Mattress Make and Model: _____ Braden Scale: _____
☐ Floor to Ceiling Pole - ceiling height: _____in/cm Location _____
☐ Toilet Safety Frame
☐ 4 wheel walker - handle hght: _____in/cm
☐ Bath Seat (circle one) no back / with back
☐ Bath Board
☐ Commode (circle one) stationary / wheeled
☐ Overbed Table

Other Equipment: Please specify dimensions or sizes for wheelchairs, cushions, slings etc.

Item	Equipment Particulars (dimensions W x D x H, etc.)

Step 5: Delivery Details

Bed Bugs: ☐ In client's home ☐ In client's building ☐ None known
Stairs into home: _____ number ☐ Carpeted ☐ Curved ☐ Stair Glide ☐ None
Other potential hazards in home: