

Health Equipment Loan Program - Short Term Loan Extension Request

Note: Loan extensions may only be granted up to an additional 3 months

www.redcross.ca/help

Please fill out this form in its entirety. Incomplete forms cannot be processed.

Client: Personal health number:			
Last name:	First name: _		
Phone Number:	Birthdate (DD/MM/YYY	Y):	Gender: M / F
Address:	City:		Province:
The following to be completed by an approved registered Health Care Professional			
Please extend the equipment below for: \Box 1 month \Box 2 months \Box 3 months			
What equipment is being extended:			
To be eligible for an extension of the equipment loaned from the Red Cross Basic Loan Program, the following criteria must be met:			
\Box The absence of equipment poses a significant risk of injury to the caregiver or client			
AND (select one of the options below):			
\square Client requires equipment for up to 3 additional months to recover from injury			
☐ Client has purchased the equipment and is waiting for its arrival within the next 3 months Anticipated arrival date:			
☐ Client has been approved for equipments	nent by another organiza	tion/program and i	s waiting for its arrival within the next 3
Funding Organization name:	W	hen equipment is e	expected:
Date referral initiated:			
\square Client is wait-listed for a facility			
Date facility process was initiated:	Date facility process was initiated: Estimated time before placement:		
☐ Client is registered with BC Palliative Care Benefits Program			
\Box I, the above client's HCP, have reviewed the equipment and the length of loan with the above client. The client understands that this is a short term loan and the equipment must be returned at the end of the extension period indicated above.			
Health Care Professional (HCP) Name:			Designation:
HCP Phone Number:			
Date (DD/MM/YYYY):			