Health Equipment Loan Program
Short Term Loan Referral Form - B.C.

Fax Form To: ____________

Please contact your local Red Cross to confirm equipment availability

Equipped for independence www.redcross.ca/help

Client: Last Name:_______________________________________ First Name:______________________________

Address:____ City: ______________________ Province: _______

Postal Code: _____________ Phone Number: ____________________ Birthyear (YYYY): ______ Gender: M / F

Height (cm/in): _________ Weight (kg/lb): _________ Personal Health Number _________________________________

Additional Information: ____

Alternate Contact: Name:____________________________________ Phone Number:__________________________

Adjustable Bath Chair
☐ Back or ☐ No Back

Bath Board
☐ Flush

Bath Transfer Bench
☐ Arm on Right ☐ Arm on Left
☐ Padded or ☐ Plastic

Bathtub Safety Rail
☐ Clamp On or ☐ Suction

Other _________________________

Frame Walker
Handgrip-Floor Height: _______inches
☐ Two Wheels or ☐ No Wheels
☐ Pediatric ☐ Wide
☐ Glide Brakes
☐ Glide Caps/Ski (recommended for carpet)

Gutter Attachment
Gutter-Floor Height: ________inches
☐ Left ☐ Right ☐ Both
☐ **Walker Tray**
☐ **Side/Hemi Walker**
Handgrip-Floor Height: _______inches

Wheelchair
☐ Standard ☐ Pediatric
☐ Transport ☐ Reclining
Seat Width:
☐ 12” ☐ 14” ☐ 16” ☐ 18” ☐ 20”
☐ 22” ☐ 24”
Seat-to-Floor Height:
☐ Standard (19”) ☐ Hemi (17.5”)
(All chairs come with footrests)

Elevating Leg Rests
☐ Right ☐ Left ☐ Both

Foam Cushion (not avail. in all sites)
☐ 16”x 16” ☐ 18” x 16” ☐ 18” x 18”

Commode
☐ Stationary ☐ Pediatric
☐ Wheeled ☐ Shower

Other: _________________________

Raised Toilet Seat
☐ 2” ☐ 4” ☐ 5”/6”
☐ Left Cut Out ☐ Right Cut Out
☐ Clamp On ☐ No Clamp
☐ 5” With Attached Arm Rests
☐ Elongated toilet seat elevator
☐ **Toilet Safety Frame**

Four Wheeled Walker
Seat-Floor Height: ___________inches
Handgrip-Floor Height: _______inches
☐ Standard ☐ Wide
☐ Basket ☐ Tray

Other: _________________________

Crutches
Crutch Height: _____________ Inches
☐ Axilla ☐ Pediatric
☐ Forearm
Hand grip Height: ___________inches

Gutter Attachment
Gutter-Floor Height: ________inches
☐ Left ☐ Right ☐ Both

Cane
Cane Height: _______________inches
☐ Single ☐ Pair

Quad Cane
☐ Right Side ☐ Left Side
☐ Small Base ☐ Large Base

Other
☐ Bed Assist
☐ IV Pole
☐ Bed Cradle
☐ Overbed Table

Referring Health Care Professional: Full Name: ____

Signature: ____________________________________ Phone Number: ____________________________________

Professional Designation (circle one): RN / OT / PT / DR / Other (specify): _______________________________

Place of Work: __________________________ Anticipated Length of Loan: 1___ 2___ 3___ 4___ 5___ 6___month(s)

Additional Information:____Referral Date: ______- _______ - ______

Month Day Year

Rev. April 2014