Health Equipment Loan Program - Referral Form - Alberta

NOTE: Equipment substitutions must be approved by your Health Care Professional
Please contact your local Red Cross to confirm equipment availability
Fax form to:_____
www.redcross.ca/help

Client: Last name:_____ First name: _____ Phone Number: _____
Birthyear (YYYY): _____ Gender: M / F Height (cm/in): _____ Weight (kg/lb): _____
Height / weight is critical to ensure client is provided with suitable, safe equipment
Address:_____City: _____Province:_____
Postal code:_____ Personal health number:_____
Alternate Contact: Name:_____Alternate Phone Number:_____

Adjustable Bath Chair ☐ Bath Chair with back ☐ No Back or ☐ Bath stool **Bath Board** ☐ Flush **Bath Transfer Bench** ☐ Arm on Right ☐ Arm on Left ☐ Padded or ☐ Plastic **Bathtub Safety Rail** ☐ Clamp On Other _____	**Frame Walker** Handgrip to Floor Height: _____inches ☐ Two Wheels or ☐ No Wheels ☐ Wide ☐ Glide Caps (recommended for carpet) **Gutter Attachment** Gutter to Floor Height: _____inches ☐ Left ☐ Right ☐ Both ☐ **Walker Tray** ☐ **Side/Hemi Walker** Handgrip to Floor Height_____inches	**Wheelchair** ☐ Self propelled ☐ Pediatric ☐ Reclining Seat Width: ☐ 12" ☐ 14" ☐ 16" ☐ 18" ☐ 20" ☐ 22" ☐ 24" **Transport Wheelchair** ☐ 15" ☐ 17" ☐ 19" ☐ 22" (Width) **Seat-to-Floor Height**: (all types) ☐ Standard (19") ☐ Hemi (17.5") (All chairs come with footrests) **Standard Leg Rests** ☐ Both **Elevating Leg Rests** ☐ Both ☐ **Seat belt**
Commode ☐ Stationary ☐ Wheeled ☐ Shower Other: _____	**Four Wheeled Walker** Seat to Floor Height: _____inches Handgrip to Floor Height: ____inches ☐ Standard ☐ Wide ☐ Basket ☐ Tray Other: _____	**Cane** Cane Height: _____inches ☐ Single ☐ Pair **Quad Cane** ☐ Right Side ☐ Left Side ☐ Small Base ☐ Large Base
Raised Toilet Seat ☐ 2" ☐ 4" ☐ 5"/6" (Round) ☐ Left Cut Out ☐ Right Cut Out ☐ 5" Round seat w/ arms ☐ 3.5" Elongated toilet seat w/ arms ☐ 3.5" Elongated toilet seat elevator ☐ **Toilet Safety Frame**	**Crutches** Crutch Height: _____ inches ☐ Axilla ☐ Pediatric ☐ Forearm Hand grip Height: _____inches **Gutter Attachment** Gutter-Floor Height: _____inches ☐ Left ☐ Right ☐ Both	**Other** ☐ Bed Assist ☐ IV Pole ☐ Bed Cradle ☐ Overbed Table

Referring Health Care Professional: Print 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:_____Surgery Date_____ ☐Palliative: Referral Date: MM-DD –YY _____