Phone: 604-485-3211 Ext 4361
Mon – Fri 10:00AM – 2:00PM
5000 Joyce Ave. Powell River, BC

Health Equipment Loan Program

Short Term Loan Referral Form

Fax Form To: 604-485-3284

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: ______________________________ Palliative: ☐

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 Other: ______________
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___ month(s)

Additional Information:______________________Referral Date: ______- _______ - _______

Month Day Year