CANADIAN RED CROSS
CROIX-ROUGE CANADIENNE

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
☐ 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 to Floor Height: _____inches
☐ Two Wheels or ☐ No Wheels
☐ Pediatric ☐ Wide
☐ Glide Caps/Skis (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
☐ 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
☐ **Seat belt**
Other: _____

Commode
☐ Stationary ☐ Pediatric
☐ 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"
☐ Left Cut Out ☐ Right Cut Out
☐ Clamp On ☐ No Clamp
☐ 5" With Attached Arm Rests
☐ 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: 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: MM-DD –YY _____