Canadian Red Cross
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# Health Equipment Loan Program (HELP)
# Recommendation Form

**Client Information** *(please print clearly)*

Last name:_____ First Name:_____

Date of birth:_____ Gender: ☐ M ☐ F ☐ T

Weight:_____ Height:_____ Language(s):_____

Street address:_____ City:_____

Postal code:_____ Province:_____

Home phone number:_____ Alternate phone number:_____

Emergency contact name:_____ Relationship to client:_____

Phone number:_____ Alternate phone number:_____

**Recommended Equipment Information** *(monthly rental rates will apply)*

☐ Wheelchair, please check preferred seat width:
☐ 14" ☐ 16" ☐ 18" ☐ 20" ☐ 22"
Option: ☐ Right elevating legrest
☐ Left elevating legrest

☐ Transport/companion wheelchair, please check preferred seat width:
☐ 15" ☐ 16" ☐ 17" ☐ 18"

☐ Folding standard walker, handles set at ___"
Option: ☐ 2 front wheels

☐ Rollator walker, handles set at ___"

☐ Cane, circle tip type: single or quad, ___" high

☐ Crutches
☐ Commode (stationary only)
☐ Bath transfer bench
☐ Bath board
☐ Bath Seat (no back support)
Option: ☐ with back support
☐ Raised toilet seat (no handle)
Option: ☐ with handles
☐ Toilet safety frame
☐ Bathtub safety rail (clamp on)
☐ Reachers/grabbers

If the recommended equipment is not available, please list acceptable substitutions here:_____

_____

- Has the client been instructed on the use of this/these aid(s)? ☐ Yes ☐ No
- Are the physical facilities in the client's residence adequate for safe effective placement of the equipment? ☐ Yes ☐ No ☐ Unknown
- Expected rental duration: ☐ 1 month ☐ 2 months ☐ 3 months ☐ Unknown

**Referral Agency Information**

Referral Completed by:_____ Date:_____

Referred from (name of clinic, hospital, etc.):_____

Professional designation:_____ Phone #:_____

Signature:_____

**Please fax or email completed form or give to client**

Equipped for independence.