



Canadian Red Cross
Renfrew County Branch
1217 Pembroke St E
Pembroke, ON, K8A 7R8
Phone: 613-735-1157
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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)

- | | |
|--|--|
| <input type="checkbox"/> Wheelchair, please check preferred seat width:
<input type="checkbox"/> 14" <input type="checkbox"/> 16" <input type="checkbox"/> 18" <input type="checkbox"/> 20" <input type="checkbox"/> 22"
Option: <input type="checkbox"/> Right elevating legrest
<input type="checkbox"/> Left elevating legrest | <input type="checkbox"/> Crutches
<input type="checkbox"/> Commode (stationary only)
<input type="checkbox"/> Bath transfer bench
<input type="checkbox"/> Bath board |
| <input type="checkbox"/> Transport/companion wheelchair, please
check preferred seat width:
<input type="checkbox"/> 15" <input type="checkbox"/> 16" <input type="checkbox"/> 17" <input type="checkbox"/> 18" | <input type="checkbox"/> Bath Seat (no back support)
Option: <input type="checkbox"/> with back support |
| <input type="checkbox"/> Folding standard walker, handles set at ____"
Option: <input type="checkbox"/> 2 front wheels | <input type="checkbox"/> Raised toilet seat (no handle)
Option: <input type="checkbox"/> with handles |
| <input type="checkbox"/> Rollator walker, handles set at ____" | <input type="checkbox"/> Toilet safety frame |
| <input type="checkbox"/> Cane, circle tip type: single or quad, ____" high | <input type="checkbox"/> Bathtub safety rail (clamp on) |
| | <input type="checkbox"/> 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.