HELP – Community Program Recommendation Form

MAXIMUM – 3 MONTH LOAN PERIOD

Please complete form and fax or email to The Canadian Red Cross

(Client must contact local office to confirm equipment availability, receipt of referral by fax and to book an appointment to receive loan).

PEIHelp@redcross.ca

Charlottetown Office	**Summerside Office**	**O'Leary Office**	**St. Peters Office**
29 Paramount Drive	10 Slemon Park Drive	14 MacKinnon Drive	1968 Cardigan Road
Charlottetown, PEI	Summerside, PEI	O'Leary, PEI	St. Peters, PEI
P: 902-628-6262	P: 902-724-2724	P: 902-859-3685	P: 902-961-2485
F: 902-368-3037	F: 902-724-5299	F: 859-2529	F:961-2119

Palliative: ☐ ***Elective Surgery:*** ☐

Client Name:_____

Please Print

Address: _____

Clients Phone # : _____ **Postal code** :_____

Height: _____ **Weight:** _____ **Birth Date:** _____

Alternate contact :_____**Alternate contact Phone # :**_____

Item(s) Required

- ☐ Straight Cane
- ☐ Standard Crutches
- ☐ Standard Commode
- ☐ Over the toilet Commode
- ☐ Raised Toilet Seat /no Arms
- ☐ Raised Toilet Seat/with Arms
- ☐ Shower Chair/with Back
- ☐ Shower Chair/ no back
- ☐ Bath Transfer Bench
- ☐ Transport Chair
- ☐ Wheelchair (elevated leg rests? __ left or __ right)
- ☐ Other _____
- ☐ Quad Cane
- ☐ Bed Assist Rail
- ☐ Bath Board
- ☐ Tub Safety Grab Bar
- ☐ Versa Frame/Toilet Arms
- ☐ Walker/no wheels ___" high
- ☐ 2 Wheeled Walker/Ski ___" high
- ☐ 2 Wheeled Walker no/ski___" high
- ☐ Rollator (4 Wheeled Walker) ___" high

Note: A Limited Amount of Bariatric Equipment is Available

REGISTERED HEALTH PROFESSIONAL (please complete)

Name: _____ Contact #_____

Please Print

Signature:_____Designation: _____

Date: _____