Long Reach Village Center, 8775 Cloudleap Court, Suite #11
Columbia, MD 21045 • loancloset@howardcountymd.gov
410-313-0363 (VOICE/RELAY) • 410-313-0369 (FAX)
www.howardcountymd.gov/loancloset

Provider Referral for Equipment

EQUIPMENT IS SUBJECT TO AVAILABILITY AND CONSUMERS MUST BE ABLE TO LOAD AND UNLOAD DONATED AND/OR RECEIVED EQUIPMENT INDEPENDENTLY

Client Contact Information: (please print)

Name: ______________________________ Phone #: ___________________________

Height:___________ Weight:_________ DOB:________

Check **(in respective box) equipment recommendations:**

	Mobility		Mobility		ADL's		ADL's
	Standard Wheelchair		Knee Walker		Bedrail		Reacher
	Transport Wheelchair		U-Step		Shower Seat		Long-Handled Shoe Horn
	Standard Walker		Spryte (Stand Assist)		Tub Transfer Bench		Sock Aid
	Two Wheeled Walker		Cane (specify type)		3-in-1 Commode		Leg Lifter
	Sliders/Tennis Balls		Crutches		Toilet Safety Rails		Dressing Stick
	Basket/Tray		Forearm Crutches		Raised Toilet Seat		Foam Cushion – Size?
	Rollator Walker		Transfer Board		Tub Safety Rail		Gel Cushion – Size?
	Hemi-Walker		Gait Belt		Bedside Table		Incontinence Supplies
	Walker Platform		Other:		Pedal Exerciser		Other:

Provider Notes: ____

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Provider Contact Information: (please print)

Name: ______________________________ PT [ ] OT [ ] MD [ ] License #___________

Organization:____

Address:____

City, State, Zip Code: ____

Email:________________________________Phone:_______________________________

1) *I am a health care professional, acting within my scope of practice, and have the authority to recommend the identified equipment.* ***Provider Initials***________

2) *In my professional judgement, the above-named client is able to safely use the identified equipment.*
   [ ] I will provide and/or have provided training to client/caregiver
   [ ] Client is able to use independently without additional training

3) *Is this equipment needed for:*
   [ ] Short-term basis *(less than 90 days)*
   [ ] Long-term basis *If* ***YES*** *are you submitting under client's insurance benefit* ***[ ] YES [ ] NO***
   If ***NOT*** *why?* ______________________________

Provider Signature:__________________________________**Date:**____________________

Updated 12/18/17