

HEALTHCARE PROVIDER REFERRAL FOR EQUIPMENT



APPOINTMENTS REQUIRED TO PICK UP EQUIPMENT
 Please complete form in its **entirety** (including your email address)
Please Fax or email this form to The Loan Closet DIRECTLY
Fax: 410-313-0369
Email: loancloset@howardcountymd.gov
 Staff will make 2 attempts to contact client
 Client must be able to load and unload equipment independently

CLIENT INFORMATION – CLIENT OR CAREGIVER MUST BE A HOWARD COUNTY RESIDENT

First & Last Name		Date
Street Address		
City	State	ZIP
Phone	E-mail Address	
DOB	HT:	WT:

REFERRING HEALTH CARE PROVIDER

Name	Title	License #
Organization		
Address	City/State	Zip
Phone	E-mail Address	

EQUIPMENT IS SUBJECT TO AVAILABILITY

<input checked="" type="checkbox"/>	Item	Item #	<input checked="" type="checkbox"/>	Item	Item #	<input checked="" type="checkbox"/>	Item	Item #
	Bedrail			Hemi-Walker			Transfer Board	
	Bedside Commode			Knee Walker			Tub Safety Rails	
	Bedside Table			Leg Lifter			Tub Transfer Bench	
	Cane (specify type)			Long Handled Shoe Horn			Walker – Balls/Slides	
	Crutches			Pedal Exerciser			Walker – Basket/Tray	
	Crutches-Forearm			Reacher			Walker Platform	
	Cushion-Foam (size)			Rollator			Walker – Standard	
	Cushion-Gel (size)			Shower Seat (specify type)			Walker – Two-Wheeled	
	Dressing Stick			Sock Aid			Wheelchair – Manual	
	Elevated Toilet Seat			Spryte (Stand Assist)			Wheelchair – Transport	
	Gait Belt			Toilet Safety Rails			U-Step	
	Other:			Other:			Other:	

Provider Notes: _____

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) Are you submitting under client's insurance benefit **YES** **NO**
 Long-term basis If **NO** why? _____

Provider Signature: _____ **Date:** _____