

**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](mailto: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**

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

**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:** \_\_\_\_\_