HEALTHCARE PROVIDER REFERRAL FOR EQUIPMENT

The Loan Closet of Howard County
Equipment and Resources for Aging in Place
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

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

✓	Item	Item #	✓	Item	Item #	✓	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)
   ☐ **Long-term basis**

Are you submitting under client's insurance benefit ☐ **YES** ☐ **NO**
If **NO** why? _____

Provider Signature: **Date:**