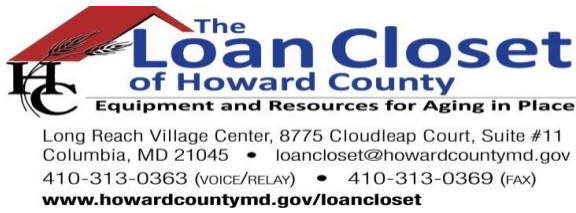


HEALTHCARE PROVIDER REFERRAL FOR EQUIPMENT



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								
☒	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) Are you submitting under client's insurance benefit ☐ YES ☐ NO ☐ Long-term basis If NO why? _____								
Provider Signature: _____						Date: _____		