Quit Connection

# *Smokers' Helpline*
# CONFIDENTIAL
# Fax Referral Form
# Fax: 1 877 513-5334

smokers'helpline
CONNECT TO QUIT
smokershelpline.ca
1 877 513-5333

## HEALTH PROFESSIONAL REFERRAL SOURCE – REQUIRED – PLEASE PRINT

**Health Care provider** (select one)

❍ Physician ❍ Nurse ❍ Dentist ❍ Pharmacist ❍ Physiotherapist ❍ Other (specify)_____

**Contact Information of Referring Clinician**

(or include fax transmissible stamp with equivalent information)

_____ _____

First name Last name

(_____)_____ (_____)_____

Telephone Fax

Office stamp

## PATIENT/CLIENT- CONTACT INFORMATION – REQUIRED – PLEASE PRINT

_____ _____

FIRST NAME LAST NAME

_____ _____

STREET ADDRESS CITY/TOWN

Ontario _____ _____ _____

PROVINCE POSTAL CODE BIRTHDATE (mm/yyyy)

(_____) _____

TELEPHONE

❍ Home ❍ Cell ❍ Work

_____

email ADDRESS (optional)

Language preference of service

❍ English ❍ French

❍ Interpreter requested (specify language) _____

Gender

❍ Male ❍ Female

❍ Other _____

*Smokers' Helpline* usually calls the client within 3 business days of receiving a referral. When should we call?

Please call me in the ❍ Morning ❍ Afternoon ❍ Evening ❍ Anytime

May we leave a message identifying ourselves as *Smokers' Helpline*? ❍ Yes ❍ No

## PATIENT/CLIENT-INFORMED CONSENT

I give permission for this form to be faxed to *Smokers' Helpline* (SHL), so that SHL can contact me regarding my attempt to quit smoking, and also for SHL to communicate with my healthcare provider. I understand that SHL will keep my information confidential and will only use it for the purpose of administering the fax referral program.

SIGNATURE OF CLIENT DATE (mm/dd/yyyy)



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