



HEALTH PROFESSIONAL REFERRAL SOURCE – REQUIRED – PLEASE PRINT

Health Professional Discipline (Please select one) Facility/Region _____

Physician
 Nurse
 Pharmacist
 Respiratory Therapist
 Dental Hygienist
 Social Worker
 Chiropractor
 Dietitian
 Other:(PLEASE SPECIFY) _____
 Name: _____ Telephone:() _____

PATIENT / CLIENT- CONTACT INFORMATION – PLEASE PRINT

_____ FIRST NAME	_____ LAST NAME
_____ STREET ADDRESS New Brunswick	_____ CITY/TOWN
_____ PROVINCE	_____ POSTAL CODE
_____ TELEPHONE <input type="radio"/> Home <input type="radio"/> Cell <input type="radio"/> Work	Language preference <input type="radio"/> English <input type="radio"/> French
_____ ALTERNATE TELEPHONE (optional) <input type="radio"/> Home <input type="radio"/> Cell <input type="radio"/> Work	Gender <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> _____
_____ Email ADDRESS	(Females only) Are you pregnant? <input type="radio"/> Yes <input type="radio"/> No Have you given birth within the past 6 months? <input type="radio"/> Yes <input type="radio"/> No

The 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.

SIGNATURE OF CLIENT/PATIENT DATE (month/day/year)