NB anti-tobacco COALITION antitabac du N.-B.

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

RÉGIE RÉGIONALE DE LA SANTÉ BEAUSÉJOUR REGIONAL HEALTH AUTHORITY

## 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 CITY/TOWN

New Brunswick _____
PROVINCE POSTAL CODE

(_____) _____
TELEPHONE
❍ Home ❍ Cell ❍Work

(_____) _____
ALTERNATE TELEPHONE (optional)
❍ Home ❍ Cell ❍Work

_____
Email ADDRESS

Language preference
❍ English ❍ French

Gender
❍ Male ❍ Female ❍ _____

**(Females only)**
Are you pregnant?
❍ Yes ❍ No
Have you given birth within the past 6 months?
❍ Yes ❍ 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)

This fax is private and confidential and may contain privileged information. It is intended for Smokers' Helpline only. If you have received this fax in error please notify the sender and destroy this faxed message immediately. Any unauthorized use or disclosure of this faxed information is strictly prohibited.

Form Revised September 2008.