

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)