



**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

Language preference  
 English     French

(    ) \_\_\_\_\_  
ALTERNATE TELEPHONE (optional)  
 Home     Cell     Work

Gender  
 Male     Female     \_\_\_\_\_

\_\_\_\_\_ Email ADDRESS

**(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) \_\_\_\_\_