

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)