Quit Connection

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

smokers' helpline
1-877-513-5333 smokershelpline.ca

REFERRAL SOURCE – REQUIRED – PLEASE PRINT

Health Care Provider (select one)

❍ Physician ❍ Nurse ❍ Dentist ❍ Pharmacist ❍ Physiotherapist ❍ Other (specify)_____

Contact Information of Referring Clinician
(or include fax transmissible stamp with equivalent information)

_____ _____
First name Last name

(_____)_____ (_____)_____
Telephone Fax

Office stamp

PATIENT / CLIENT- CONTACT INFORMATION – REQUIRED – PLEASE PRINT

_____ _____
FIRST NAME LAST NAME

_____ _____
STREET ADDRESS CITY/TOWN

Ontario_____ _____ _____
PROVINCE POSTAL CODE BIRTHDATE (mm/yyyy)

(_____) _____
TELEPHONE
❍ Home ❍ Cell ❍ Work

_____
email ADDRESS (optional)

Language preference of service
❍ English ❍ French
❍ Interpreter requested (specify language) _____

Gender
❍ Male ❍ Female ❍ Identify as: _____

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 / VERBAL CONSENT

It is understood that this form will be faxed to Smokers' Helpline (SHL), so that SHL can contact the referred individual regarding his or her attempt to quit smoking, and also for SHL to communicate with the referring healthcare provider. SHL will keep all information confidential and secure and will only use it for the purpose of administering the fax referral program

SIGNATURE (of either the patient / client being referred or of the individual who obtained verbal consent) DATE (mm/dd/yyyy)

Template Revised April 2016