Quit Connection

Smokers' Helpline

CONFIDENTIAL

Fax Referral Form

smokers'helpline

CONNECT TO QUIT
smokershelpline.ca
1 877 513-5333

Manitoba

HEALTHCARE PROVIDER REFERRAL SOURCE – REQUIRED – PLEASE PRINT

Healthcare provider (select one)

❍ Physician ❍ Nurse ❍ Dentist ❍ Pharmacist ❍ Respiratory Therapist ❍ Other (specify)_____

Contact Information of Referring Healthcare Provider
(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

Manitoba _____ _____ _____
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
❍ Other _____

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. I understand that SHL will keep my information confidential and will only use it for the purpose of administering the fax referral program.

SIGNATURE OF CLIENT DATE (mm/dd/yyyy)