



Smokers' Helpline



CONFIDENTIAL

CONNECT TO QUIT
smokershelpline.ca
1 877 513-5333

Fax Referral Form

New Brunswick

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
New Brunswick
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)