



# Smokers' Helpline



CONFIDENTIAL

CONNECT TO QUIT  
smokershelpline.ca  
1 877 513-5333

## Fax Referral Form

Prince Edward Island

### 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  
Prince Edward Island  
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)