

CONFIDENTIAL

Referral Form

NEW BRUNSWICK

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

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 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)