

## CONFIDENTIAL

### Referral Form

SASKATCHEWAN

**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

Saskatchewan  
\_\_\_\_\_  
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)