STOP SMOKING WORKSHOP – CONFIDENTIAL REFERRAL FORM

**IF EXTERNAL FAX TO: 519-633-0468**

# PATIENT/CLIENT – CONTACT INFORMATION – **REQUIRED** – PLEASE PRINT

|  |  |
| --- | --- |
| First Name: | Last Name: |
| Telephone: | Email (optional): |
| Alt. Telephone: | May we leave a message identifying ourselves as Southwestern Public Health (Circle)? Yes / No |

# HEALTH CARE PROVIDER INFORMATION – IF KNOWN PLEASE PRINT

|  |  |
| --- | --- |
| Organization: | Date: |
| First Name: | Last Name: |
| Telephone: | Fax: |

# MEDICAL INFORMATION – Recommended to help us refer you better

|  |
| --- |
| Are you AGE 15 or older (Circle)? Yes / No |
| How many cigarettes do you smoke per day? \_\_\_\_\_\_ |
| Are you Currently pregnant or breastfeeding (Circle)? Yes / No |
| Other questions (please check if yes):   * Recipient of Ontario Works (OW) or Ontario Disability Support Program (ODSP) * Patient of a Family Health Team or Community Health Centre * Client of the Canadian Mental Health Association |

# PATIENT/CLIENT INFORMED/VERBAL CONSENT

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| It is understood that this form will be faxed to Southwestern Public Health (SWPH), so that SWPH can contact the referred individual regarding their attempt to quit smoking, and for SWPH to communicate with the referring Health Care Provider. SWPH will keep all information confidential and secure and will only use it for the purpose of administering the referral program.  SIGNATURE (of either the patient/client being referred or individual who obtained verbal consent) DATE (mm/dd/yyyy) |

This fax is confidential and may contain privileged information. It is intended for Southwestern Public Health only. If you have received this in error, please notify the sender and destroy it immediately. Any unauthorized use or disclosure of this information is strictly prohibited.