NSW Quitline Referral Form

Fax the completed form to: **02 9698 2740**

(If you receive this fax by mistake, please re-fax to above number)

Quitline 13 7848

Client/patient details

Surname: **Given Names:** **Sex:** ○ Male ○ Female **Date of birth:** *(Optional)* **Postcode:**

Preferred phone number:

Home | Work | Mobile

Preferred date of first call:

Preferred day/s to call:

☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun

Preferred time/s to call :

☐ 9am – 12pm ☐ 12pm – 5pm ☐ 5pm – 8pm

Is it OK to leave a message? ○ Yes ○ No

Interpreter required: ○ Yes ○ No

If yes, specify language:

Is the client/patient of Aboriginal or Torres Strait Island origin?

○ Yes ○ No ○ Not stated/unknown

Health conditions: ***(To be filled by health professionals only)***

☐ Diabetes ☐ Asthma ☐ Pregnancy

☐ Heart Disease ☐ Depression ☐ Breastfeeding

☐ Respiratory Disease ☐ Anxiety ☐ Cancer

Other, please specify:

Smoking Cessation Pharmacotherapy currently used or prescribed:

☐ Bupropion ☐ Varenicline ☐ Nicotine Replacement Therapy

Other, please specify:

Smoking habits:

Cigarettes per day:

Time to first cigarette:

○ 0–5 minutes ○ 5–30 minutes ○ 30–60 minutes ○ 60+ minutes

Referrer details

Name: **Organisation:**

Address: **Suburb:** **State:** **Postcode:**

Preferred contact method:

Phone | Fax | Email

Profession:

☐ Doctor
☐ Nurse
☐ Allied Health
☐ Dental Practitioner
☐ Optometrist
☐ Pharmacist
☐ Health Worker
☐ Midwife
☐ Psychologist

Other, please specify:

Setting:

☐ General Practice
☐ Hospital
☐ Pharmacy
☐ Public Oral Health
☐ Antenatal Service
☐ Quit for New Life
☐ Aboriginal Health Service
☐ Mental Health Service
☐ Alcohol & Drug Service
☐ Community Service
☐ Health Promotion Unit
☐ Get Healthy Information & Coaching Service
☐ Get Healthy at Work

Other, please specify:

Acknowledgement:

☐ I acknowledge that the client/patient named above has been provided with information about the Quitline and has provided verbal informed consent to their information being sent to the NSW Quitline.

Name: **Date:**

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