myquit.ca · 1.877.376.1701

CONFIDENTIAL
Fax Referral Form
Fax: 1-877-513-5334

REFERRAL SOURCE – REQUIRED – PLEASE PRINT

Discipline (select one)

❍ Physician ❍ Nurse ❍ Dentist ❍ Pharmacist ❍ Respiratory Therapist ❍ Other _____

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 or PREFERRED NAME LAST NAME

_____ _____
STREET ADDRESS CITY/TOWN

Ontario _____ _____ _____
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 _____

CALLS ARE USUALLY ATTEMPTED 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 MyQuit or Smokers' Helpline? ❍ Yes ❍ No

INFORMED / VERBAL CONSENT

It is understood by the referred individual that this form will be submitted to MyQuit partner Smokers' Helpline so that the referred individual can be contacted by a MyQuit partner regarding his or her attempt to quit smoking. The referred individual understands that his or her information will be kept secure and confidential and will only be used for the purpose of administering and evaluating the MyQuit program.

SIGNATURE (of either the referred individual or the individual who obtained verbal consent) DATE (mm/dd/yyyy)

Updated: April 2015, V3