CONFIDENTIAL Fax:

visit the website for your local fax number: myquit.ca

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