Canadian Cancer Society / Société canadienne du cancer

Smokers' Helpline
1 877 513-5333
www.smokershelpline.ca

Smokers' Helpline
Fax: 1 877 513-5334
CONFIDENTIAL
Fax Referral Form

St Joseph's Health Care London

HEALTH PROFESSIONAL REFERRAL SOURCE – REQUIRED – PLEASE PRINT

Please select one: O Inpatient O Outpatient

Department (Please select one) O Stroke/Neuro O ABI O SCI O Amputee O Fitness Centre

O Other:(Please Specify) _____

Anticipated Date of Patient Discharge _____ (mm/dd/yyyy)

Health Professional Discipline (Please select one) O Physician O Nurse O Social Worker O Pharmacist

O Physiotherapist O Occupational Therapist O Respiratory Therapist O Psychologist O Dietician

O Other:(Please Specify) _____ Telephone (____) _____

FIRST NAME _____ LAST NAME _____

PATIENT / CLIENT- CONTACT INFORMATION – PLEASE PRINT

FIRST NAME _____ LAST NAME _____

STREET ADDRESS _____ CITY/TOWN _____

PROVINCE Ontario POSTAL CODE _____ BIRTHDATE (mm/yyyy) _____

(____) _____
TELEPHONE
O Home O Cell O Work

(____) _____
ALTERNATE TELEPHONE (optional)
O Home O Cell O Work

_____
email ADDRESS (optional)

Language preference
O English O French

Gender
O Male O Female O _____

(Females only)
Are you pregnant?
O Yes O No
Have you given birth within the past 6 months?
O Yes O No

The *Smokers' Helpline* usually calls the client within 3 business days of receiving a referral. When should we call?

Please call me in the O Morning O Afternoon O Evening O Anytime

May we leave a message identifying ourselves as *Smokers' Helpline*? O Yes O No

PATIENT / CLIENT-INFORMED CONSENT

I give permission for this form to be faxed to *Smokers' Helpline* (SHL), so that SHL can contact me regarding my attempt to quit smoking, and also for SHL to communicate with my healthcare provider. I understand that SHL will keep my information confidential and will only use it for the purpose of administering the fax referral program.

_____
SIGNATURE OF PATIENT/CLIENT DATE (mm/dd/yyyy)