



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



CONNECT TO QUIT  
[smokershelpline.ca](http://smokershelpline.ca)  
 1 877 513-5333

**HEALTHCARE PROVIDER REFERRAL SOURCE – REQUIRED – PLEASE PRINT**

**Healthcare provider** (select one)

- Physician    Nurse    Dentist    Pharmacist    Respiratory Therapist    Other (specify) \_\_\_\_\_

**Contact Information of Referring Healthcare Provider**  
 (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                      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) \_\_\_\_\_

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Gender

Male       Female

Other \_\_\_\_\_

**Smokers' Helpline usually calls the client 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 *Smokers' Helpline*?    Yes     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 CLIENT                      DATE (mm/dd/yyyy)