HELPING U 2 QUIT PROGRAM

NSW Health Promotion Northern NSW Local Health District

REFERRAL FORM

Disclaimer
This program has been designed to assist and support people to quit smoking. Please note it is not intended to replace independent professional medical advice. People who have medical conditions, suffered from depression, anxiety or another mental illness, are taking medicines, and/or are pregnant or breastfeeding are encouraged to talk to a doctor before participating in this program.

Client consent (Please ensure client understands the following before signing)

I agree to participate in the ***Helping U 2 Quit program***. I understand that I will be contacted by the ***Helping U 2 Quit Coordinator*** and asked questions regarding my smoking. I also understand that my referring health professional and/or General Practitioner will be notified of my participation. As part of the program, I consent to be contacted at 3, 6 and 12 months to follow up on my progress.

Client name:			
Gender:	Male		Female
Telephone:	Landline:		Mobile:
Address:			
Email address:			
Date of Birth:			
Preferred program structure:	3 weeks	6 weeks	Either
	Day	Evening	Either
Signature:			
Date:			

Referring practitioner details

Practitioner name:	
Profession:	
Organisation:	
Address:	
Telephone:	
Fax:	
Email:	

Please fax completed form to Gavin Dart at (02) 6622 2151
or email to gavin.dart@ncahs.health.nsw.gov.au