

CONFIDENTIAL- PRIVACY WARNING. The information in this fax message is intended for Quitline staff only. If you are not the intended recipient you must not copy, distribute, take any action reliant on, or disclose any details of the information in this fax to any other person or organisation.

To refer a patient/client to the ACT Quitline for help with smoking cessation, please fill in the following:

Health professional contact details (please print clearly)

Practice name: _____

Town/Suburb (and postcode): _____

Referring health professional's name: _____

Telephone number: _____

Patient/Client contact details (please print clearly)

Patient/Client's name: _____

Age: ____ Patient's preferred phone no/s (h) _____ (w) _____ (m) _____

Is it okay for the Quitline to leave a message? Yes No

Preferred date for first call

Preferred time of first call (please circle): Mon Tues Wed Thurs Fri AM PM

Please note: Calls to the ACT Quitline will be answered 24 hours a day 7 days a week. However, *Quitline advisors* will only be available Monday through Friday 10.00am – 5.00pm, (excluding public holidays).

Are you currently using any medication? Yes No

Do you have any other health conditions relevant to quitting smoking?

Heart disease Respiratory/lung disease Diabetes

Depression/anxiety Pregnancy

Other – please specify: _____

I consent to this information being faxed to the Quitline and for the Quitline to call me at a time that I have suggested on this form. I understand that persons within the organisation with access to the fax machine may view this form. In response to this fax referral, Quitline staff will call the patient/client as close as possible to the nominated time to provide information, support and advice on smoking cessation.

Patient's signature: _____

Date: _____