

Referral to Quitline
Fax to: 02 6257 5055

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To refer a patient/client to the 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 Tue Wed Thu Fri Sat Sun AM PM

Please note: Calls to the Quitline will be answered 24 hours a day 7 days a week. However, *Quitline advisors* will only be available Monday through Friday 7.00am – 10.30pm and 9.00 am – 5.00 pm on weekends and 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: _____