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

Markham Stouffville Hospital Corporation
☐ Markham Site ☐ Uxbridge Site

Health Professional Referral Source - REQUIRED - Please Print

UNIT (Select one)

☐ Outpatient ☐ Maternal/child ☐ Mental Health
☐ Surgical ☐ Medical ☐ Other _____

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

Health Professional Disipline (Select one)

☐ RD ☐ RN/RPN ☐ RRT ☐ OT/PT ☐ PA ☐ SW

Other (Please Specify) _____ Telephone ( ) _____

_____ _____
FIRST NAME LAST NAME

Patient / Client - Contact Information - Required

_____ _____
FIRST NAME LAST NAME

_____ _____
STREET ADDRESS CITY / TOWN

ONTARIO _____ _____ _____
PROVINCE POSTAL CODE BIRTHDATE (mm/dd/yyyy)

_____
TELEPHONE
☐ HOME ☐ CELL ☐ WORK

_____
ALTERNATE TELEPHONE
☐ HOME ☐ CELL ☐ WORK

_____
email address (optional)

Language preference ☐ English ☐ French

Gender ☐ Male ☐ Female ☐ _____

(Females only)
Are you pregnant?
☐ Yes ☐ No

Have you given birth within the past 6 months?
☐ Yes ☐ 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 ☐ Morning ☐ Afternoon ☐ Evening ☐ Anytime

May we leave a messagae 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 PATIENT / CLIENT DATE (mm/dd/yyyy)

This fax is private and confidential and may contain privleged information. It is intended for Smokers' Helpline only. If you have received this fax in error please notify the sender and destroy this faxed message immediately. Any unauthorized use or disclosure of this faxed information is strictly prohibited.