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

Quit Connection
SASKATCHEWAN

smokers' helpline
1-877-513-5333 smokershelpline.ca

HEALTHCARE PROVIDER REFERRAL SOURCE – REQUIRED – PLEASE PRINT

Healthcare Provider (select one)

○ Physician ○ Nurse ◉ Dentist ○ Pharmacist ○ Physiotherapist ○ Social Worker

○ Other:(specify) _____

Contact Information of Referring 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

Saskatchewan _____ _____
PROVINCE POSTAL CODE BIRTHDATE (mm/yyyy)

(_____) _____
TELEPHONE
○ HOME ○ CELL ○ WORK

_____
EMAIL ADDRESS (optional)

Language preference of service
○ English ○ French
○ Interpreter requested (specify language below)

Gender
○ Male ◉ Female ○ Identify as: _____

Does patient wish to self-identify as an Aboriginal person such as First Nations, Metis or Inuit? ○ Yes ○ No
We offer culturally sensitive cessation counselling to Indigenous clients if the client self-discloses this information.

When should Smokers' Helpline call?

Please call me in the: ○ Morning ○ Afternoon ○ Evening ○ Anytime

PATIENT / CLIENT-INFORMED/VERBAL CONSENT

It is understood that this form will be faxed to Smokers' Helpline (SHL), so that SHL can contact the referred individual regarding his or her attempt to quit smoking, and also for SHL to communicate with the referring healthcare provider. SHL will keep all information confidential and will only use it for the purpose of administering the referral program.

SIGNATURE (of either patient/client being referred or of the individual who obtained verbal consent) DATE (mm/dd/yyyy)

Template Revised March 2021