MARKHAM STOUFFVILLE HOSPITAL CORPORATION

Smokers' Helpline
Fax to: 1-877-513-5334
CONFIDENTIAL

☐ Markham Site ☐ Uxbridge Site

SMOKERS' HELPLINE REFERRAL

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

NAME _____ BIRTHDATE (mm/dd/yyyy) _____

STREET ADDRESS _____ CITY / TOWN _____

PROVINCE ONTARIO POSTAL CODE _____

TELEPHONE ☐ HOME ☐ WORK ☐ CELL

Language preference ☐ English ☐ French

Gender ☐ Male ☐ Female ☐ _____

ALTERNATE TELEPHONE ☐ HOME ☐ WORK ☐ CELL

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

EMAIL ADDRESS (optional)

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.