

Information collected by the Quitline will be treated **confidentially** and will not be released to other entities unless required by law.

Client/patient details			
Surname:		Given names:	
		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth: / /
Postal address: <i>(please include suburb)</i>			Postcode:
Home phone:		Work phone:	
Mobile:		Email:	
Preferred day/s to call: <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday			
Preferred time/s to call: <input type="checkbox"/> 7am – 9am <input type="checkbox"/> 9am – 12pm <input type="checkbox"/> 12pm – 5pm <input type="checkbox"/> 5pm – 8.30pm <input type="checkbox"/> 8.30pm – 10pm			
Is it OK to leave message? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Health issues: <input type="checkbox"/> Diabetes Type 1 <input type="checkbox"/> Pregnancy/Breastfeeding <input type="checkbox"/> Diabetes Type 2 <input type="checkbox"/> Epilepsy <input type="checkbox"/> Heart Disease <input type="checkbox"/> Anxiety <input type="checkbox"/> Respiratory Disease <input type="checkbox"/> Depression Other details:		Aboriginal and Torres Strait Islander origin: <i>(please indicate one only)</i> <input type="checkbox"/> Aboriginal and Torres Strait Islander <input type="checkbox"/> Not stated/unknown <input type="checkbox"/> Aboriginal but not Torres Strait Islander <input type="checkbox"/> Neither <input type="checkbox"/> Torres Strait Islander but not Aboriginal South Sea Islander status: <i>(please indicate one only)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No Would you like to speak to an Aboriginal and/or Torres Strait Islander staff member? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Smoking Cessation Pharmacotherapy: <input type="checkbox"/> Nicotine Replacement Therapy <input type="checkbox"/> Bupropion <input type="checkbox"/> Varenicline Other details:			

Referrer details			
Name:		Organisation:	
Address: <i>(please include suburb)</i>			Postcode:
Phone number:		Email:	
Profession: <input type="checkbox"/> Doctor <input type="checkbox"/> Optometrist <input type="checkbox"/> Nurse <input type="checkbox"/> Pharmacist <input type="checkbox"/> Allied health <input type="checkbox"/> Health Worker <input type="checkbox"/> Dentist Other details:		Setting: <input type="checkbox"/> General Practice <input type="checkbox"/> Indigenous Health Service <input type="checkbox"/> Hospital <input type="checkbox"/> Mental Health Service <input type="checkbox"/> Pharmacy <input type="checkbox"/> Alcohol and Drug Service <input type="checkbox"/> Dental Practice <input type="checkbox"/> Community Service Other details:	

I acknowledge that I have informed my clients of this referral to the Quitline service

Signature: _____ Date: / /