

CLIENT DETAILS

Surname:			Given Name:		
Sex: Female Male Indeterminate			Date of birth:		
Referring: Pregnant woman Partner Woman planning pregnancy within 6 months			Phone number:		
Postal address: (A Post Office Box number is acceptable)			Is it OK for Quitline to leave a message? Yes No		
Suburb:			Postcode:		
Email address:			Complete this section if referring pregnant woman		
			Pregnancy due date:		CO Monitor Reading:
			URN: (Queensland Health facilities only)		

Important information for client: calls from Quitline will appear as a BLOCKED or PRIVATE number.

Aboriginal and Torres Strait Islander origin

Aboriginal and Torres Strait Islander	Aboriginal but not Torres Strait Islander	Torres Strait Islander but not Aboriginal
Not stated/unknown	Neither	

Would the client like to speak to an Aboriginal and/or Torres Strait Islander Quitline staff member? Yes No preference

Client availability to receive a call from Quitline:

Weekdays				Weekends			
Morning	Afternoon	Evening	Any time	Morning	Afternoon	Evening	Any time

Additional information:

Terms of participation – Please inform your patient before signing

- Program participants are eligible to one 12 week course of Nicotine Replacement Therapy (NRT). A clinical assessment for the provision of NRT will be undertaken during first contact with Quitline. The participant agrees NRT will be used only as directed and will not be shared with another person.
- Quitline will attempt to contact participants during their time. If contact is unsuccessful, Quitline will leave a message unless indicated above.
- Participation in the program is voluntary. Participants can **leave** the program at any time. The program is provided at **NO COST** to the participant.

Privacy notice:

Personal information, including sensitive information, collected by the Department of Health is handled in accordance with the Information Privacy Act 2009. The purpose of this form is so that patients may be referred to the Quitline service for information, advice and assistance. All personal information will be securely stored and only accessible by authorised officers of the department. Demographical information, such as gender, age group, suburb and cultural background may be used for our statistics, but will not include any identifiable information. Personal information will not be disclosed to third parties without consent, unless required or authorised by law.

REFERRER DETAILS
I acknowledge that I have informed my patient of this referral to the Quitline service and my patient consents to the terms of participation as outlined above.
Agree Date:

First name:		Last name:	
Phone number:		Email:	
Setting: Antenatal clinic Specialist clinic Hospital General Practice Indigenous health service Other		Profession: Midwife Nurse Allied Health Doctor Health Worker Other	
		Facility: <i>E.g. Sunshine Hospital or XYZ medical centre</i>	
		Hospital and Health Service: (Queensland Health facilities only)	

Return completed form to Quitline:
 Email: 13QUIT@health.qld.gov.au Fax: 07 3259 8217