Quitline 13 7848

Quit for You…Quit for Baby

REFERRAL FORM

Queensland Government

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

Client details

Surname:

Given names:

Sex: ☐ M ☐ F ☐ I

Address: *(please include suburb)*

Postcode:

Date of birth: / /

Mobile:

Home/Work:

Is it OK to leave message? ☐ Yes ☐ No

IMPORTANT INFORMATION FOR CLIENT: Calls from Quitline will appear as an UNKNOWN number.

Preferred day to call: Any day ☐ Weekday ☐ Weekend ☐ *Note: evening is not available on the weekends*

Preferred time/s to call: Any time ☐ Morning ☐ Afternoon ☐ Evening ☐

Email:

Is a translator required? ☐ Yes ☐ No

If yes - please specify a language:

Complete this section if referring pregnant person

Due date: / / CO Monitor Reading:

URN *(QLD Health facilities only):*

Aboriginal and Torres Strait Islander origin: *(please indicate one only)*

☐ Aboriginal and Torres Strait Islander
☐ Aboriginal but not Torres Strait Islander
☐ Torres Strait Islander but not Aboriginal
☐ Not stated / Unknown
☐ Neither

Referring: ☐ Pregnant person ☐ Partner ☐ Person or partner planning pregnancy within 6 months

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

Terms of participation – please inform your patient before signing

1. 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.
2. Quitline will attempt to contact participants during their time. If contact is unsuccessful, Quitline will leave a message unless indicated above.
3. 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 (this section must be completed)

I acknowledge that I have informed my client of this referral to the Quitline service and my client has provided consent.

Agree: ☐ Date: / /

Name:

Facility/organisation:

Address:

Email: Phone:

Complete this section if referring from a Queensland Health facility

Hospital and Health Service:

Setting:
- ◯ Antenatal clinic
- ◯ Specialist clinic
- ◯ Hospital
- ◯ General Practice
- ◯ Indigenous health service
- Other:

Profession:
- ◯ Midwife
- ◯ Nurse
- ◯ Allied Health
- ◯ Doctor
- ◯ Health Worker
- Other:

For more information or copies of this form visit: **https://www.health.qld.gov.au/public-health/topics/atod/quitline-hp-referral-form**

Clear form

Return completed form to Quitline

Email: **13QUIT@health.qld.gov.au** Fax: **(07) 3259 8217**

Email form *Print form* *Save form*