**Referral to Quitline**

**Has the patient/client consented to a referral? Yes/No**

**Is it ok to leave a message? Yes/No**

**If there is no phone may we send a letter? Yes /No**

**IF COMPLETING MANUALLY, PLEASE PRINT CLEARLY**

|  |
| --- |
| **Patient/client’s information** |
| First Name |  |
| Last Name |  | Date of Birth |  |
| NHI |  | Pregnant? |  |
| Gender |  | Ethnicity |  |
| Address |  |
| Post Code |  |
| Home Number |  | Work number |  |
|  Mobile |  |

**Has NRT been dispensed? Yes/No**

|  |
| --- |
| **Referrer’s information** |
| Name |  |
| Organisation |  |
| Email |  |
| Date |  |

**Please send to Quitline by fax (04 460 9879) or email (****referrals@quit.org.nz****)**