**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 |  |
| NHI |  | Gestation (weeks) |  |
| Partner of the patient? |  | Gender |  |
| Date of Birth |  | Ethnicity |  |
| Address |  |
| Post Code |  |
| Home number |  | Work number |  |
| Mobile |  |

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

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

**Please send to Quitline by email (****referrals@quit.org.nz****)**

To access forms online go to [www.midwife.org.nz](http://www.midwife.org.nz)