Shape

Description automatically generated with medium confidence

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| **Smoking Cessation Referral Form** | |
| **Client Name\*** |  |
| **Address\* +** |  |
| **Postcode\*** |  |
| **NHS Number** |  |
| **Date of Birth\*** |  |
| **Contact Number Landline** | ( |
| **Contact Number Mobile\*** | ) |
| **What is the best time of day to call?** | Morning □ Afternoon □ Evening □ Anytime □ |
| **Does the client require to quit as a preparation to an operation? \*** | Yes □ No □ |
| **Has the client been diagnosed with a Mental Health Condition? \*** | Yes □ No □ |
| **Is the client pregnant? \*** | Yes □ Due Date……………….....… No □ |
| **Consent has been obtained from the client to share their details with Solutions4Health for assistance to stop smoking\* (please tick)** | Yes □ No □ |
| **Name of referring Practice / Pharmacy / Other\*** |  |
| **Name of GP / Health Professional / Pharmacist\*** |  |
| **Date of referral\*** |  |
| **Additional notes (optional)** |  |

Head Office: Unit 1 Thames Court, 2 Richfield Avenue, Reading, Berkshire, RG1 8EQ | T: 01183 341860

Please email completed referral to smokefreelife.berkshire@nhs.net

REFERRAL Sep 22 v4