**Referrer Information**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Date of referral |  | Is referral via an NHS Health Check? | | | Y/N | | |
| Agency Name |  | Name of referring professional | | |  | | |
| Agency Address |  | | | | | | |
|  |  | | | | | Postcode |  |
| Telephone |  | |  |
| Email |  | | | | | | |
| Reason for Referral |  | | | | | | |

**Patient Information**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient Name |  | | | | | | | | | | | DOB | |  | | | | | | |
| Address |  | | | | | | | | | | | Postcode | |  | | | | | | |
|  |  | | | | | | | | | | | Consent to post | | Y/N | | | | | | |
| Primary contact no (if consent for phone) |  | | | | | | | | | | | Email (if consented) | |  | | | | | | |
| Consent for SMS | Y/N | | | | | | | | | | |  | |  | | | | | | |
| Gender | Male |  | | Female | | |  | Transgender | | |  |  |  |  |  |  |  |  |  |  |
| Is an Interpreter needed? | | | Yes | |  | No | | |  | If yes, please specify language | | | |  | | | | | | |
| Is the Service User disabled? | | | Yes | |  | No | | |  |  | | | |  | | | | | | |
| If yes, please provide details of accessibility needs | | |  | | | | | | | | | | | | | | | | | |
| GP Name & Address | | |  | | | | | | | | | | | | | | | | | |
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Age started smoking Number of cigarettes smoked per day

Previously quit?

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Yes |  | No |  | If yes, please specify how (NRT’s, Champix… etc) | | |  | | | | |
|  | | | | |  |  | | |  | | |
| Mental Health Diagnosis | | | | | Y/N | Details | | |  | | |
| Pregnant or Breastfeeding | | | | | Y/N | | | | | | |
| Current Adult or Child Safeguarding concerns or involvement with services? | | | | | Y/N | Details | | |  | | |
| I confirm that I have consent to make this referral (and in the case of a referral aged 12-15, is Gillick competent or caregiver has consent) | | | | | | | |  | | Date |  |

**Please send completed form to:**

**Email:** [RQS@viaorg.uk](mailto:RQS@viaorg.uk)

**Secure email:** [RedbridgeQuitsSmoking@wdp.cjsm.net](mailto:RedbridgeQuitsSmoking@wdp.cjsm.net)