**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 |  |
|  |  |

|  |
| --- |
|  |

|  |
| --- |
|  |

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

**Secure email:** RedbridgeQuitsSmoking@wdp.cjsm.net