

Take Control

TOB-CS-FORM-11

Personal Tobacco-Free Counselling

One on one intensive free counseling available to assist smokers and spit tobacco users become tobacco free!

REFERRAL FAX

<u>Fax to:</u> Becky Bridgman Tobacco Quit Nurse, Public Health Nurse Fax: (807) 625-4824 Tel: (807) 625-5982	<u>From:</u> (stamp or write your contact information here)
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Client Consent and Personal Information Section:

I understand that an employee from the Thunder Bay District Health Unit will be contacting me to discuss and arrange for participation in a Tobacco Cessation Program. My participation is voluntary. I understand that any information I provide will be kept confidential. I give the Tobacco Cessation Program and the referring health care professional permission to discuss my quit status if deemed necessary.

Client's Name (please print)

Client signature

Verbal consent received

Person obtaining verbal consent (sign)

Patient is medically approved to use nicotine patch, gum, inhaler or lozenges at a dose recommended by manufacturer.

Patient is not approved to use nicotine patch, gum, inhaler or lozenges.

Date of Birth: _____

Phone Number: _____

Health Unit Only:

Client reached, appointment made _____

Client reached, declined services _____

Unable to reach _____

