Take Control Personal Tobacco-Free Counselling *One on one intensive free counseling available to assist with smoking and vaping cessation!*	**Fax to (807) 625-4824** **Joanne Powell, PHN** Tobacco Cessation Nurse Phone: (807) 625-5982

CLIENT REFERRAL FORM

Client Last Name:________________________ First Name:________________________ Address:____ Postal Code:_______________________ Date of Birth:_____________________ Day/month/year Health Card #____________________________ Phone #__________________________	**Stamp/Sticker/Notes**

Referred By Name:____________________________ Organization:______________________________ Phone #:__________________________ ☐ Verbal Consent Received ☐ Patient is medically approved to use nicotine patch, gum, inhaler, quickmist or lozenges at a dose recommended by the manufacturer. Signature:_________________________________	**Stamp/Sticker/Notes**

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 Signature:____________________________