

# Referral Form

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Quitline**  
**13 7848**  
Tasmania

## REFERRER INFORMATION

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ORGANISATION: \_\_\_\_\_ FAX: \_\_\_\_\_

EMAIL: \_\_\_\_\_

## CLIENT INFORMATION

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

PHONE: \_\_\_\_\_ POST CODE: \_\_\_\_\_

|                                                    |                                                                       |     |                         |         |
|----------------------------------------------------|-----------------------------------------------------------------------|-----|-------------------------|---------|
| Aboriginal and/or Torres Strait Islander status:   | NO                                                                    | YES | Prefer not to say       | UNKNOWN |
| Requirement for interpreter:                       | NO                                                                    | YES | If yes, what language?: |         |
| National Relay Service required?                   | NO                                                                    | YES | If yes, what language?: |         |
| Preferred day to call: Mon   Tue   Wed   Thu   Fri | Preferred time to call: Anytime (8am-8pm)   8am-12pm   12-4pm   4-8pm |     |                         |         |



For a limited time your clients may receive free NRT (nicotine replacement products) - patches +/- oral product such as lozenges or gum - saving them up to \$100 a month. **NB: only medical/nurse practitioners can endorse the provision of these free NRT products.**

REFERRER TYPE: ☐ Doctor ☐ Pharmacist ☐ Midwife ☐ Allied health ☐ Dental practitioner  
☒ Please tick ☐ Nurse ☐ Psychologist ☐ Optometrist ☐ Community/health worker ☐ Other: (please specify) \_\_\_\_\_

DO YOU ENDORSE FREE NRT FOR THIS CLIENT? ☐ YES ☐ NO

CLIENT'S HEALTH CONDITIONS: ☐ Under 45kg ☐ Cancer ☐ Recent/upcoming surgery ☐ Pregnancy  
☒ Please tick ☐ Diabetes ☐ Heart disease/ recent cardiac event ☐ COPD/respiratory condition ☐ Mental health condition and/or recent psychosis and/or prescribed Olanzapine/Clozapine

Please note any other relevant client information, and adjustments to NRT dosage if applicable:

Privacy is important to us and we treat your information with respect, integrity and honesty in keeping with our core values and as governed by the Privacy Act. Personal information is only collected as necessary for agreed Quit programs or activities. Our full Privacy Policy may be accessed here at: [quittas.org.au/privacy](http://quittas.org.au/privacy)

**SUBMIT THIS FORM  
USING ONE OPTION:**

- HealthLink: search by practice name 'quit'
- Email: [quitline@quittas.org.au](mailto:quitline@quittas.org.au)
- Online form: [quittas.org.au/referral-form](http://quittas.org.au/referral-form)
- Fax: 03 6223 1944

**QuitTas**



[admin@quittas.org.au](mailto:admin@quittas.org.au)



[quittas.org.au](http://quittas.org.au)



(03) 6169 1943