Referral Form

Quitline 13 7848 Tasmania

Date: ___/___/___

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?:	
Preferred time to call:	Anytime (8am-8pm) | 8am-12pm | 12-4pm | 4-8pm			
Prescriber endorsement for free NRT*	YES	NO	*Nicotine Replacement therapy (patches +/- oral product)	

NOTES: Please list any health concerns, eg. asthma, diabetes, pregnancy, mental health conditions, etc.

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

SUBMIT THIS FORM USING ONE OPTION:

- HealthLink: search by practice name 'quit'
- Online form: quittas.org.au/referral-form
- Email: quittline@quittas.org.au
- Fax: 03 6223 1944

QuitTas

admin@quittas.org.au quittas.org.au (03) 6169 1943