quitnow ca

Quit Smoking
Support from QuitNow

FAX REFERRAL

Fax To: 1-888-857-6555

"Quitting smoking is the best thing you can do for your health. We know that many people want to quit smoking. QuitNow is free in BC and they will help you quit smoking."

PATIENT INFORMATION (patient sticker can be placed here)

Patient First Name: ______________________

Patient Last Name: ______________________

Male ☐ Female ☐ Another ☐ Prefer not to answer ☐

Year of Birth (yyyy): ______________________

REFERRAL SOURCE INFORMATION (sticker can be placed here)

Referral Agent: ______________________

First Name: ____________ Last Name: ____________

Email: ____________ Phone: ____________

Fax: ____________ Postal Code: ____________

Organization: ______________________

Referral Agent Type: ☐ Doctor ☐ Hospital ☐ Pharmacist ☐ Other

"What kind of support do you want from QuitNow? Phone, web or text?"

TYPE OF SERVICE REQUESTED

☐ Phone

Phone Number: ______________________

If contact method is by phone, what is the best time to contact you?

NOTE: QuitNow will make three attempts to contact you. (Check all that apply)

Weekday --> ☐ Morning ☐ Afternoon ☐ Evening

Weekend --> ☐ Morning ☐ Afternoon

Patient would like phone coaching to be translated into:

____

(Over 300 languages available in under a minute)

☐ Web

Email Address: ______________________

Patient can self register by going to www.quitnow.ca

☐ Text

Cell Number: ______________________

Patient can self register by texting the word QUITNOW to 654321

"Before I refer you to QuitNow, please let me know if you consent to the following:"

NOTE: please read the four statements below to the patient and ensure the boxes are checked.

PATIENT CONSENT

☐ By checking this box, I consent to a fax or electronical referral to QuitNow. I may receive services within the next week in the way that I have requested. This is a free service. If I have requested Text Services, standard message and data rates apply.

☐ Is it OK for the Coach to leave a phone message if they miss you?

☐ By checking this box, I will allow QuitNow to inform my referral agent about the outcome of my enrolment with their service.

☐ By checking this box, I consent to contact by QuitNow for research/evaluation purposes to improve service.

Patient Signature	Date (yyyy/mm/dd)

The information on this form is being collected under the Freedom of Information and Protection of Privacy Act 26 (c)&(e) and will be used to provide smoking cessation services to you and for ongoing research and program evaluation of our services. For more information regarding the collection, use and disclosure of your personal information, please contact the Privacy Officer, British Columbia Lung Foundation, PO Box 34009 Station D, Vancouver, British Columbia, V6J 4M2, privacy.officer@bclung.ca, 1-800-665-5864.

BRITISH COLUMBIA

BC LUNG FOUNDATION