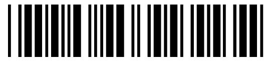
fraserhealth

SMOKING CESSATION CLINIC REFERRAL
Jim Pattison Outpatient Care and Surgery Centre



FAX TO 604-582-3744

PATIENT'S FULL LEGAL NAME: ______________________ **GENDER:** ☐ M ☐ F
Last First Middle

PERSONAL HEALTH NUMBER: ______________________ **DATE OF BIRTH:** ______________
DD/MM/YYYY

ADDRESS: ______________________
Street City Province Postal Code

HOME PHONE NO. ______________ **ALTERNATE PHONE NO.** ______________ **Primary Language** ______________

Insurance Type: ☐ MSP ☐ WCB ☐ Out of Province ☐ Self-Pay ☐ RCMP or Armed Forces #: __________

SMOKING HISTORY:

NUMBER OF PAST QUIT ATTEMPTS: ______________________

PREVIOUS USE OF NICOTINE REPLACEMENT THERAPY ☐ YES ☐ NO

If yes, which method ☐ PATCH ☐ LOZENGE ☐ GUM ☐ OTHER ______________________

PREVIOUS USE OF COMBINATION NICOTINE REPLACEMENT THERAPY ☐ YES ☐ NO

If yes, please describe: ______________________

PREVIOUS USE OF: CHAMPIX ☐ YES ☐ NO
ZYBAN ☐ YES ☐ NO

ADVERSE REACTIONS IF NOTED: ______________________

CLINICAL HISTORY:

CURRENT MEDICATIONS:

____

☐ SEIZURE DISORDER
☐ PREGNANT

☐ MENTAL HEALTH
☐ Depression
☐ Anxiety
☐ Other ______________

FAMILY PHYSICIAN (if different from referral source)	**REFERRING HEALTH CARE PROVIDER**
Name: ______________	Name: ______________
MSP#: ______________	MSP#: ______________
Phone: FAX:	Phone: FAX:

Referring physician signature: ______________________ **Date:** (dd/mm/yyyy): ______________

***Referral to the smoking cessation clinic may include spirometry to assess lung health and/or consult with clinic physician**