



Fax Referral Form
I QUIT NOW helpline
Fax : 514-255-9856 or 1-866-255-9856

HEALTH CARE PROVIDER REFERRAL SOURCE – REQUIRED – PLEASE PRINT

Health Care Provider (select one)

Doctor Dentist Dental hygienists Optometrist Pharmacist Respiratory Therapist

Contact Information of Referring Health Care Provider
(or include fax transmissible stamp with equivalent information)

First name Last Name
(_____) (_____) _____
Telephone Fax

Office stamp

PATIENT – CONTACT INFORMATION – REQUIRED – PLEASE PRINT

FIRST NAME LAST NAME

STREET ADDRESS CITY/TOWN
Quebec _____
PROVINCE POSTAL CODE BIRTHDATE (mm/yyyy)

(_____) _____
TELEPHONE
 Home Cell Work

Language preference of service
 English French

EMAIL address (optional)

Gender
 Male Female

The I QUIT NOW helpline usually calls the client within 3 business days of receiving a referral.

When should we call?

Please call me in the Morning Afternoon Evening Anytime

May we leave a message identifying ourselves as the I QUIT NOW helpline? Yes No

PATIENT – INFORMED CONSENT

I give permission for this form to be faxed to the I QUIT NOW helpline, so that I QUIT NOW helpline can contact me regarding my attempt to quit smoking. I understand that the I QUIT NOW helpline will keep my information confidential and will only use it for the purpose of administering the fax referral program.

SIGNATURE OF CLIENT

DATE (mm/dd/yyyy)