

“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 <input type="checkbox"/> Female <input type="checkbox"/>
Date of Birth (yyyy/mm/dd): _____

**REFERRAL SOURCE INFORMATION** (sticker can be placed here)

Yes, as a referral agent this is my first referral to QuitNow

Referral Agent Name: _____
Referral Agent Organization: _____
Referral Agent Type: <input type="checkbox"/> Doctor <input type="checkbox"/> Hospital <input type="checkbox"/> Pharmacist <input type="checkbox"/> Other
Phone: _____ Fax: _____

“How would you like QuitNow to contact you? They can contact you by email, text message or phone.”

**TYPE OF SERVICE REQUESTED**

<input type="checkbox"/> Online	Email Address	
<input type="checkbox"/> Text	Cell Number	
<input type="checkbox"/> Phone	Phone Number	Is it OK to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No
Can QuitNow contact you for research/evaluation purposes (to improve service)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
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 →	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening	
Weekend →	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon	
Language Preference for Phone Service (available in 130 languages): _____		

“Would you please sign this form to indicate you agree with my referral?”

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

**PATIENT AGREEMENT TO REFERRAL**

<input type="checkbox"/> By checking this box, I give permission to my referral agent to fax or send electronically 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.	
<input type="checkbox"/> By checking this box, I agree to let QuitNow send information about my enrolment in this service to my referral agent listed above.	
Patient Signature	Date Signed (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 Association, PO Box 34009 Station D, Vancouver, British Columbia, V6J 4M2, [privacy.officer@bc.lung.ca](mailto:privacy.officer@bc.lung.ca), 1-800-665-5864

