SMOKING CESSATION CLINIC – REFERRAL FORM

Name:		Hospital No.:	
DOB:			
Address:			
Post Code:		Contact Tel. No.:	

Diagnosis: ____

____

Consultant:__________________________ **Referral Date**:________________________

SMOKING HISTORY:	
Age Started:	
Current number of cigarettes per day/tobacco per day?	
Has the patient had previous nicotine replacement therapy?	YES/NO
Has the patient attended a stop smoking service in the last six months?	YES/NO

Date:................................ Name:... Contact/Bleep:.............................

Signature:.. Position:...

Please send the referral to Deborah Beach / Claire Chalwin, Cardiac Rehab Department, Harefield Hosp.
Telephone & Fax No. 01895 828 944, Bleep no. 6131