Health Care Professional Email Referral

Go Smoke-Free NB
Vivez Sans Fumée NB
telephone support 1-866-366-3667

Email to: gosmokefreenb@HorizonNB.ca

Health Care Provider referral source information (required)- Please complete electronically

Health Professional Discipline: (Please select one) **Name of Workplace**:

☐ Physician ☐ Nurse Practitioner ☐ Nurse ☐ Respiratory Therapist ☐ Dental Hygienist

☐ Pharmacist ☐ Social Worker ☐ Dietician ☐ Other (please specify)

Provider Name: **Telephone**:

If you would like to receive an update from Go Smoke-Free NB on this patient's consult, please provide your email address:

Patient/Client Information (required) - Please complete electronically

First Name: **Last Name:**

Street Address: **City/Town:**

Province: New Brunswick **Postal Code**:

Language Preference: ◯ English ◯ French **Gender:** ◯ M ◯ F ◯ Identify as:

Are you pregnant? ◯ Yes ◯ No **Have you given birth in past 6 months?** ◯ Yes ◯ No

Telephone: (506) **Alternate Telephone (optional):**

Email Address (optional):

***Go Smoke-Free NB* will contact the client on the next business day once the referral is received**

What is the best time to call? ◯ Morning ◯ Afternoon ◯ Evening ◯ No preference

May we leave a message identifying ourselves as *Go Smoke-Free NB*? ◯ Yes ◯ No

Patient/Client informed /verbal consent (required)

It is understood that this form will be emailed to Go Smoke-Free NB, so they can contact the referred individual regarding their attempt to quit smoking, and communicate information with the referring healthcare provider. The referred individual agrees to share this information with Go Smoke-Free NB. Go Smoke-Free NB will keep all information confidential and will only use it for the purposes of administering this program.

Patient/Client or Healthcare Provider Signature:

Date: