## **Tobacco Free Nova Scotia**



## CONFIDENTIAL

## **Tobacco Free Nova Scotia**

**Fax Referral Form** 

http://tobaccofree.novascotia.ca

1-844-926-0243

8-1-1

## **Nova Scotia**

Healthcare Provider Referral Source – Required – Please Print					
Healthcare provider (select of Physician Nurse Dentist Contact information of Refer (or include fax transmissible	Pharmacist ring Healthcare Pro			Other (sp	ecify)
First Name () Telephone	Last Name ()Fax				
Patient/Client – Contact Information – Required – Please Print					
FIRST NAME			LAST NA	ME	
STREET ADDRESS		CITY/TOWN			
PROVINCE		POSTAL CODE BIRTHI		BIRTHDATE (mm/dd/yyyy)	
() TELEPHONE Home Cell Work		-	Language preference of service English French Interpreter requested (specify language)		
EMAIL ADDRESS (optional)		_	Gender Male Fer	nale Oth	er
Tobacco Free Nova Scotia us	sually calls the clien	t within 3 busi	iness days of re	ceiving ref	erral. When should we call?
Please call me in the May we leave a message ide	Morning ntifying ourselves as	Afternoon Tobacco Free	Evening Nova Scotia?		Anytime No
Patient/Client-Information C	onsent				
I give permission for this form to be faxed to Tobacco Free Nova Scotia, so that Tobacco Free Nova Scotia can contact me regarding my attempt to quit smoking, and also for Tobacco Free Nova Scotia to communicate with my healthcare provider. I understand Tobacco Free Nova Scotia will keep my information confidential and will only use it for the purpose of administering the fax referral program					
SIGNATURE OF CLIENT			 DATF (r	nm/dd/vv	w)