CONFIDENTIAL

Brighton & Hove City Council

NHS

HOSPITAL – Domiciliary Smoking Cessation Referral Form

Please complete all sections highlighted in red and where possible provide additional information if known.

Patient's Registered GP:	**Patient's Name:**
GP Address: **Postcode:**	**Patient's Address:** **Postcode:** **D.O.B.** / / **NHS NUMBER:** / /
Referrer Name: **Referrer Address**	**Patient's Telephone No:** **Mobile No:**
Relevant Medical Conditions:	
Is the patient housebound? Please answer	**Is the patient eligible for free prescriptions?** If known please answer
Signature of Referrer:	**Date of Referral:** / /
THE PATIENT HAS GIVEN CONSENT FOR A STOP SMOKING ADVISOR TO VISIT THEM AT HOME: Please answer. ***Pharmacy use only* –Please ask the patient to sign below at the beginning of the first visit.** **I (PATIENT) GIVE INFORMED CONSENT TO RECEIVE SMOKING CESSATION ADVICE AND TREATMENT:** **PATIENT'S SIGNATURE:** **DATE :** / /	
ANY KNOWN RISKS TO SELF OR OTHERS? If known please answer (if yes please detail below)	
ANY COMMUNICATION ISSUES (BLIND, DEAF, LANGUAGE)? If known please answer (if yes please detail below)	
ANY ACCESS ISSUES? : If known please answer (if yes please detail below)	**CARER'S / KEY HOLDER'S NAME:** (if known, please state) **TELEPHONE NO:**

Please send/e-mail this form to: Anna Fairhurst St. Mary's Hall, RSCH
E-mail: anna.fairhurst@nhs.net

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