HOSPITAL – Domiciliary Smoking Cessation Referral Form

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

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| **Patient’s Registered GP:** | Patient’s Name: |
| **GP Address:** | **Patient’s Address:****Postcode:****D.O.B. / /** **NHS NUMBER: / /** |
| **Postcode:** |
| **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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