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](mailto:anna.fairhurst@nhs.net)

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