



Stop Smoking Service



BAY OF PLENTY STOP SMOKING SERVICE REFERRAL FORM

Date of Referral

1. CONTACT PERSON DETAILS

General Practitioner

Referring Health Provider

Designation

Surname

First Name

Address

Phone

Suburb

Mobile

City

Email

2. CLIENT DETAILS

Surname

First Name

Address

Phone

Suburb

Mobile

City

DOB

Gender

Female

Pregnant

NHI

Male

Client Consent

Ethnicity

Māori

NZ European

Pacific Island

Asian

Other

Specify...

3. STOP SMOKING PRACTITIONER TO SEE CLIENT AT:

Home

Drop in clinic

Hāpainga office

Workplace (Please provide details)

Other (Please provide details)

4. PREFERRED MEANS OF CONTACT:

Phone call

Text

Email

Post

5. FORWARD FORM :

Scan/Email to: hapainga@ebpha.org.nz

Mail to: Concordia House

Fax to: (07) 306 2399

17 Pyne Street

Free Phone 0800 Hāpainga (427246)

Whakatane, 3120

Clinical Policies and Procedures

File Name: Referral Form Doc HP 2016

Authorised:
Stop Smoking Lead

Date Issued:
December 2016

Review Date:
July 2017

Next Review:
June 2018

Version: 1

Page 1 of 1