Smokefree Cumbria

NHS Cumbria

Cumbria Stop Smoking Service
Referral to the Stop Smoking Service

Client Name: _____

Date of Birth: _____ NHS Number: _____

Address: _____

_____ Post Code: _____

Telephone Numbers:

Home: _____ Mobile: _____ Work: _____

Is it OK to leave messages on this/these numbers? YES/NO

How did you hear about the service? _____

Email address: _____

Preferred call back time: _____

Exempt from Prescription charges: YES/NO Pregnant: YES/NO

Client Diagnosed with:

☐ Awaiting surgery ☐ Heart Disease ☐ Diabetes
☐ Cancer ☐ Asthma ☐ Respiratory/Pulmonary Disease

Other: _____

GP Name & Address : _____

INTERESTED IN: ☐ ONE TO ONE ☐ TELEPHONE SUPPORT ☐ GROUP SESSION

CLIENT CONSENT: I agree to be referred to the Stop Smoking Service for advice and support in stopping smoking and I understand I will be contacted as soon as possible

Client Signature: _____ Date: _____

Referred by: _____ Date Referred: _____

Professional Status/Ward/Dept: _____ Contact No:_____

Please return to:- Cumbria Stop Smoking Service
Ann Burrow Thomas Health Centre
South William Street
WORKINGTON
Cumbria, CA14 2EW

Telephone and Fax No: 01228 603564

For Office Use Only:	
Date:	Action Taken