Alberta Health Services

AlbertaQuits Helpline Referral

Affix patient label within this box

Please complete all sections and fax to the AlbertaQuits Helpline at **1.866.979.3553**

Client Demographics			
Last Name		First Name	
Gender	☐ Male ☐ Female	PHN	Date of Birth *(yyyy-Mon-dd)*
Street Address			Home Phone
City		Postal Code	Alternate Phone

Contact Information

When and where would the client like to be contacted?

☐ Home Phone ☐ Alternate Phone

☐ Morning (8 am - 12 pm) ☐ Afternoon (12 pm - 6 pm) ☐ Evening (6 pm - 8 pm)

☐ Weekday ☐ Weekend

Preferred Date *(yyyy-Mon-dd)* _____

Consent for leaving message on client's voicemail recieved?

☐ Yes

☐ No

Language interpreter required?

☐ Yes, language/dialect *(specify)* _____

☐ No

Referring Source	
Physician/PCN/Program/Site	Physician Fax Number
Address	

Reason for Referral *(main concern)*

☐ Help for self

☐ Help for someone else

☐ Help during pregnancy

☐ Information

☐ Relapse prevention

☐ Other *(specify)* _____