

“Quitting smoking is the best thing you can do for your health. We know that many people want to quit smoking. QuitNow is free in BC and they will help you quit smoking.”

**PATIENT INFORMATION** (patient sticker can be placed here)

Patient First Name: \_\_\_\_\_  
 Patient Last Name: \_\_\_\_\_  
 Male  Female  Another  Prefer not to answer   
 Year of Birth (yyyy): \_\_\_\_\_

**REFERRAL SOURCE INFORMATION** (sticker can be placed here)

Referral Agent: \_\_\_\_\_  
 First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Email: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Organization: \_\_\_\_\_  
 Referral Agent Type:  Hospital  Doctor  Pharmacist  Other

“What kind of support do you want from QuitNow? Phone, web or text?”

**TYPE OF SERVICE REQUESTED**

<input type="checkbox"/> Phone Phone Number: _____ If contact method is by phone, what is the best time to contact you? NOTE: QuitNow will make three attempts to contact you. (Check all that apply.) Weekday → <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening Weekend → <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon Patient would like phone coaching to be translated into: _____ (Over 300 languages available in under a minute.)	<input type="checkbox"/> Web Email Address: _____ <i>Patient can self register by going to <a href="http://www.quitnow.ca">www.quitnow.ca</a></i>
<input type="checkbox"/> Text Cell Number: _____ <i>Patient can self register by texting the word QUITNOW to 654321</i>	

“Before I refer you to QuitNow, please let me know if you consent to the following:”

**NOTE: please read the four statements below to the patient and ensure the boxes are checked.**

**PATIENT CONSENT**

By checking this box, I consent to a fax or electronic referral to QuitNow. I may receive services within the next week in the way that I have requested. This is a free service. If I have requested Text Services, standard message and data rates apply.

Is it OK for the Coach to leave a phone message if they miss you?

By checking this box, I will allow QuitNow to inform my referral agent about the outcome of my enrolment with their service.

By checking this box, I consent to contact by QuitNow for research/evaluation purposes to improve service.

Patient Signature	Date (yyyy/mm/dd)
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The information on this form is being collected under the Freedom of Information and Protection of Privacy Act 26 (c)&(e) and will be used to provide smoking cessation services to you and for ongoing research and program evaluation of our services. For more information regarding the collection, use and disclosure of your personal information, please contact the Privacy Officer, British Columbia Lung Association, PO Box 34009 Station D, Vancouver, British Columbia, V6J 4M2, [privacy.officer@bc.lung.ca](mailto:privacy.officer@bc.lung.ca), 1-800-665-5864