

# Quitline Referral Form

Date:

To:

Quitline Queensland

Fax number:

(07) 3259 8217

Referred by:

Stamp or  
address, phone or fax

*Please note: The information in this fax is confidential and only intended for Quitline. If you have received this fax in error, please resend to 07 3259 8217 and then destroy. You must not copy, distribute, take any action on, or disclose any details of the information in this fax to any other person or organisation.*

## Client / Patient Information

Name:

Gender:

Female

Male

## Does the person have any other health issues relevant to Quitline Advisors?

Respiratory/lung disease

Diabetes

Depression

Anxiety

Pregnancy

Age related Macular Degeneration

Heart Disease

Other (please specify)

## I have agreed to receive a call from Quitline.

I consent to this information being faxed to Quitline and for Quitline staff to call me at a time that I have suggested on this form.

\_\_\_\_\_  
Client/Patient's signature

\_\_\_\_\_  
Date

Best time to call

Mon

Tue

Wed

Thu

Fri

Sat

Sun

AM (9am-12)

PM (12-5pm)

EVE (5-8pm)

Preferred phone number:

Messages from Quitline may be left:

OK

Do NOT leave messages



To obtain further copies of this form either photocopy or download from [www.health.qld.gov.au/atods](http://www.health.qld.gov.au/atods)