**Referrer Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Agency Name |  | Agency Worker |  |
| Agency Address |  |
|  |  | Postcode |  |
| Telephone |  |  |
| Email |  |
| Reason for Referral |  |

**Patient Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Name |  |  D.O.B |  |
| Address |  | Postcode |  |
|  |  |  |  |
| Primary contact no. |  | Email |  |
| Gender | Male |  | Female |  | Transgender |  |  |  |  |  |  |  |  |  |  |
| Is an Interpreter needed?  | Yes |  | No |  | If yes, please specify language |  |
| Is the Service User disabled? | Yes |  | No |  |  |  |
| If yes, please provide details |  |
| GP Name & Address |  |
|  |  |

|  |
| --- |
|  |

|  |
| --- |
|  |

Age started smoking? Number of cigarettes smoked per day?

Previously quit?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Yes |  | No |  | If yes, please specify how (NRT’s, Champix… etc) |  |
|  |  |  |  |  |  |
|  |  |  |  |
| Referrer Signature |  | Date |  |

**Please send completed form to:**

WDP Harrow

44 Bessborough Road

Harrow HA1 3DJ

**Tel:** 0300 303 2868

**Fax:** 0333 344 4651

**Email:** HarrowStopSmoking@wdp.org.uk

**Secure email:** HarrowStopSmoking@wdp.cjsm.net