**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 | | |  | | | | | | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | | |

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|  |

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](mailto:HarrowStopSmoking@wdp.org.uk)

**Secure email:** [HarrowStopSmoking@wdp.cjsm.net](mailto:HarrowStopSmoking@wdp.cjsm.net)