Alberta Health Services

Affix patient label within this box.

## AlbertaQuits Helpline Referral

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

| **Client Demographics** | | |
|---|---|---|
| Last Name | First Name | Gender ☐ Male ☐ Female |
| Street Address | | Home Phone |
| City | Postal Code | Alternate Phone |

**Contact Information**

When and where would the client like to be contacted?

☐ AM ☐ PM

☐ Weekday ☐ Weekend

☐ Home Phone

☐ Alternate Phone

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)* _____