

# Pregnancy Quitline referral form



Fax to: Quit SA 8291 4280

## Pregnant / Postnatal Woman

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ P/code \_\_\_\_\_

Phone: (hm) \_\_\_\_\_

(mobile) \_\_\_\_\_

(only provide telephone numbers likely to get you at the time of requested call)

Date of birth: ..... / ..... / .....

Are you of Aboriginal or Torres Strait Islander origin?

(please circle)

Yes / No

Quitting status:

- planning to quit  
 already quit  
 unsure about quitting

Please indicate a specific time for your first call.

(allow up to 30 minutes)

day: \_\_\_\_\_ date: \_\_\_\_\_

- Time:  8.30 am - 12:30 pm, Mon to Fri  
 12:30 pm - 5 pm, Mon to Fri  
 5 pm - 7:30 pm, Mon to Fri  
 2 pm - 5 pm, Sat/Sun (closed on public holidays)

I give consent to the Pregnancy Quitline to call me as arranged and to record notes on the database:

(client sign here): .....

In compliance with the 2001 Privacy Bill, Quit SA is required to ask the following question:

May our evaluation unit ring you for quality control purposes? (confidentiality is assured and information will only be used to assist you in quitting smoking.) (please circle)

Yes / No

Referred by:

- |   |  |
|---|--|
| <input type="checkbox"/> LMHS                     | <input type="checkbox"/> Modbury             |
| <input type="checkbox"/> Flinders Medical Centre  | <input type="checkbox"/> WCH                 |
| <input type="checkbox"/> Community health agency  | <input type="checkbox"/> GP/Med Practitioner |
| <input type="checkbox"/> Other hospital - specify | <input type="checkbox"/> Other - specify     |
- .....

Please provide referrees name and contact number:

Name: .....

Phone: .....

## Partner

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ P/code \_\_\_\_\_

Phone: (hm) \_\_\_\_\_

(mobile) \_\_\_\_\_

(only provide telephone numbers likely to get you at the time of requested call)

Date of birth: ..... / ..... / .....

Are you of Aboriginal or Torres Strait Islander origin?

(please circle)

Yes / No

Quitting status:

- planning to quit  
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Please indicate a specific time for your first call.

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| <input type="checkbox"/> Other hospital - specify | <input type="checkbox"/> Other - specify     |
- .....

Please provide referrees name and contact number:

Name: .....

Phone: .....