

Pregnancy Quitline referral form



Fax to: Quit SA 8291 4280

Pregnant / Postnatal Woman

Partner

Name: _____

Name: _____

Address: _____

Address: _____

_____ P/code _____

_____ P/code _____

Phone: (hm) _____

Phone: (hm) _____

(mobile) _____

(mobile) _____

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

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

Date of birth: / /

Date of birth: / /

Are you of Aboriginal or Torres Strait Islander origin?

(please circle)

Are you of Aboriginal or Torres Strait Islander origin?

(please circle)

Yes / No

Yes / No

Quitting status:

- planning to quit
 already quit
 unsure about quitting

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: _____

Please indicate a specific time for your first call.

(allow up to 30 minutes)

day: _____ date: _____

- Time:** 8.30 am - 1 pm, Mon to Fri
 1 pm - 5 pm, Mon to Fri
 5 pm - 8 pm, Mon to Fri
 2 pm - 5 pm, Sat/Sun & public holidays

- Time:** 8.30 am - 1 pm, Mon to Fri
 1 pm - 5 pm, Mon to Fri
 5 pm - 8 pm, Mon to Fri
 2 pm - 5 pm, Sat/Sun & public holidays

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

(client sign here):

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

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:

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: