

**SOUTH EAST HIGHLAND SMOKING CESSATION SERVICE
REFERRAL DETAILS**

Client Name		
And Address	Telephone Number(s):	
	Work:	
	Mobile:	
Postcode	Home:	
Date of Birth		
Does the client wish to be contacted at home?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Only to be completed by GP. This patient is medically suitable to receive:	Nicotine Replacement Therapy only	Smoking Cessation Advice only
Zyban Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Champix Yes <input type="checkbox"/> No <input type="checkbox"/>		
Would patient like to be seen with partner/carer	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Name and address of the Medical Practice where you are registered		
Signature		
Print Name		
Date		

Working with you make Highland the health place to be
Please send completed form to the Stop Smoking Service, Nurse Base,
60 Ardcroy Road, CROY IV2 5PL