**LIVING WELL SMOKEFREE – REFERRAL FORM**

**Please email back to** **stop.smoking@northyorks.gov.uk**

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| **Name:** |
| **Address:****Postcode:** |
| **Date of Birth:** |
| **Contact number: (landline)** |
| **Contact number: (mobile)** |
| **What is the best time of day to call?**Morning / Afternoon / Evening**May we leave a message?** Yes / No**If there is no phone may we send a letter?** Yes / No |
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| **Has the client been diagnosed with a Mental Health Condition?** Yes / No (If Yes, please supply details)  |
| **Does the client suffer from diabetes?** Yes – Type 1 Yes – Type 2 No |
| **Does the client have any other Long Term Health Conditions?**  Yes / No (If Yes, please supply details)  |
| **Is the client pregnant?** Yes / No. **Due Date:**  |
| **Is the client required to quit as a preparation for an operation?** Yes /No |
| **Does the client give consent for their data to be passed on to the stop smoking service?** Yes / No |
| **Any safeguarding concerns/risks when considering face to face contact or a home visit:** |
| **Name of GP Practice:****Name of Referring Organisation:** |