QUIT SMOKING
WITH YOUR MANITOBA PHARMACIST

PHARMACISTS MANITOBA

CLIENT REFERRAL FORM

Contact Information of Referring Provider:

Name

Telephone

Fax

Provider Type

Physician Nurse practitioner Nurse Dentist Social Worker

Respiratory Therapist Dietician Other ________

Referred To - REQUIRED

Pharmacy Name

Fax

Client/Patient Contact Information - REQUIRED

First Name

Last Name

Street Address

City/Town

Province

Postal Code

Date of Birth (mm/dd/yyyy)

PHIN #

Gender

Female Male Other ________ Rather not say

Telephone

Email (optional)

Preferred language of service

English French Other ________

Preferred time of day for contact

Morning Afternoon Evening Anytime

Client/Patient Eligibility - REQUIRED

(please confirm the client meets all of the above eligibility requirements - Required

18 years of age or older: Yes No

Smoke cigarettes: Yes No

Valid Manitoba health card #: Yes No

Be ready to set a quit date: Yes No

(note - to participate in this program, client may also use other forms of nicotine but MUST smoke cigarettes.)

Have a goal of total abstinence from tobacco: Yes No

Client/Patient Informed Consent - REQUIRED

I understand that my contact information will be provided to a pharmacy participating in *Quit Smoking With Your Manitoba Pharmacist* and I consent to being contacted by employees of that pharmacy for purposes of registering in a program to help me quit tobacco. I authorize communication between various members of my healthcare team for the purpose of providing tobacco cessation services and understanding all members of my healthcare team will keep my personal health information confidential and use it only for the purposes of providing care.

Verbal consent: Yes No

Signature: ________

Date (mm/dd/yyyy): ________

June 9, 2022