Cork University Hospital

Smoking Cessation Service Referral Form

(Form No. 509)

Date: _______/_______/_______

Patients Name: ________________________________

Address: ________________________________

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← insert patient label across **or** please write in full details **this is essential for follow up**

D.O.B. _________________ **M. R. N** ______________ **Ward** _____________

Consultants Name: ________________________________

Contact Numbers: (H) __________________ (Other) __________________

(*At least one contact number is essential for follow up)*

Reason for Referral:

____

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Please indicate the required services by ticking one or more of the following:

☐ Group Support ☐ One to one support ☐ Send stop smoking literature

Client Signature: ____________________________

(Client must be aware of referral)

Referred by: ____________________________

(Please Print)

Return Form To

Please return form via CUH internal post to: Smoking Cessation Officer, Occupational Health Dept, CUH.

And

The following wards should insert referral form into the red Smoking Cessation boxes on the ward: 3A, 3B and Step Down Ward.