

To: Quitline (Victoria)

Fax: (03) 9514 6801

Patient information – *confidential*

** mandatory fields*

***First name:** ***Last name:**

***Preferred phone no:**

Does the patient identify as being Aboriginal or Torres Strait Islander?

Yes No Unknown

What is the best time to call? Morning Midday Afternoon

Is it OK for the Quitline to leave a message? Yes No

Please note: We will attempt to contact you within your requested time block, however this may not always be possible.

Referrer details

***First name:** ***Last name:**

** mandatory fields*

***Organisation:**

***Email:**

***Phone:**

Referrer Details (cont'd)

Please select the most appropriate setting

Sector	Setting
Aboriginal organisation	Aboriginal health worker
	General or nurse practitioner
	Health promotion worker
	Koori maternity worker
	Nurse
	Oral health professional
	Pharmacist
	Psychologist/counsellor
	Tackling indigenous smoking worker
	Other allied health
Alcohol and other drugs	Care and recovery coordination
	Counselling
	Intake
	Needle and syringe program
	Peer support
	Therapeutic rehabilitation
	Withdrawal
Mental health	Acute community
	Acute inpatient
	Mental health community support service
	Specialist mental health
	Subacute community
	Subacute residential

Sector	Setting
Hospital/health service	Cardiology
	Emergency
	Maternity
	Mental health
	Oncology
	Pharmacy
	Rehabilitation
	Respiratory
	Surgery
	Other
Primary and community health	Community pharmacist
	General or nurse practitioner
	Maternal and child health
	Nurse
	Oral health professional
	Psychologist/counsellor
	Other allied health
Social and community services	Aged care
	Disability service
	Family violence service
	Financial advice/counselling
	Gambling support
	Housing/homelessness
	Prisoner/former prisoner support
	Youth services
	Other

Privacy warning:

The information in this fax is confidential and only intended for the Quitline. If you have received this fax in error please resend to (03) 9514 6801. You may not copy, distribute, take any action on, or disclose any details of the information in this fax to any other person or organisation.

Please Note:

By submitting this referral you acknowledge that your patient has consented to this information being disclosed.