Call 0800 HĀPAINGA (0800 427 246)

Stop Smoking Service

Hāpainga
Stop Smoking Service

[redacted]

BAY OF PLENTY STOP SMOKING SERVICE REFERRAL FORM

Client Consent: I agree to this consultation and give consent for my information to be shared with my doctor and/or other healthcare provider.

Signature: _____ Date of Referral: _____

1. REFERRAL DETAILS

Referring Health Service		**Designation**	
Surname		**First Name**	
Address		**Phone**	
Suburb		**Mobile**	
City		**Email**	

2. CLIENT DETAILS

General Practitioner/ Doctor

Surname			**First Name**
Address			**Phone**
Suburb			**Mobile**
City			**DOB**
Gender ☐Female ☐Male		☐Pregnant	**NHI**

Ethnicity ☐Māori ☐NZ European ☐Samoan ☐Tongan ☐Cook Islander ☐Niuean ☐Indian ☐Chinese ☐Asian ☐Other Specify...____

3. STOP SMOKING PRACTITIONER TO SEE CLIENT AT:

☐Home ☐Drop in clinic ☐Hāpainga office

Workplace (Please provide details)	
Other (Please provide details)	

4. PREFERRED MEANS OF CONTACT:

Phone call ☐	Text ☐	Email ☐	Post ☐

5. FORWARD FORM :

Scan/Email to:	hapainga@ebpha.org.nz	Mail to:	EBPHA Building
Fax to:	(07) 306 2399		5 Louvain Street
Free Phone	0800 Hāpainga (427246)		Whakatane, 3120

Submit Referral