Medication Therapy Services Clinic
Smoking Cessation Service
Patient Referral Form

Phone: 709-864-2274 Fax: 709-864-6245

Name:

MCP:

Date of Birth:

Date:

Patient Information

Address:_____

Telephone: _____ _____
(home) (cell)

Email: _____

☐ Self Referral

☐ Health professional Referral – Note: Complete box to right →

If Health Professional is making referral, is the client aware that you are referring him/her to the MTS Clinic for smoking cessation? ☐ Y ☐ N

Referring Health Professional Information

Name:_____

☐ Pharmacist
☐ Physician
☐ Dentist
☐ Nurse
☐ Social worker
☐ Occupational Therapist
☐ Respiratory Therapist
☐ Other_____

Signature:_____

Phone:_____Fax: _____

Medical Conditions: (if known)

Cardiovascular disease: ☐ Angina ☐ Prior MI ☐ Heart failure ☐ Atrial fib ☐ Other cardiac: _____

☐ Diabetes ☐ Hypertension ☐ Dyslipidemia ☐ CVA/neurological ☐ Headache – type:_____

☐ Renal – acute ☐ Renal – chronic ☐ COPD ☐ Asthma ☐ Depression ☐ Anxiety ☐ Insomnia

☐ GERD ☐ Peptic ulcer disease ☐ Arthritis – type: _____ ☐ Other Pain: _____

☐ Other:_____

Medication related issues: (if known)

Which community pharmacies does the patient use? List all:_____

Does the patient have:

- Allergies or Medication intolerances? ☐ N ☐ Y :_____
- Difficulty adhering to medications? ☐ N ☐ Y
- Cognitive impairment? ☐ N ☐ Y

If yes, who is responsible for medication administration? _____

Please provide any details/concerns which would help in our assessment: