**Everyone Health Enfield Stop Smoking Service**

**To be completed by the referring Health Professional**

All patient data is stored securely in accordance with Data Protection guidelines.

If you have a query concerning a referral please contact: 0333 005 0095

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient Details: | | | | | | | | | | |
| Title: | Mr/Mrs/Ms/Miss/Other: | | | **Date of Birth:** |  | | | | | |
| First Name |  | | | **Age: (if under 18)** |  | | | | | |
| Surname: |  | | | **Gender:** | Male | |  | Female |  | |
| Address: |  | | | | | | | | | |
| Postcode: |  | | | **NHS Number:** |  | | | | | |
| Telephone: |  | | | **Mobile:** |  | | | | | |
| Email: |  | | | | | | | | | |
| Parent/Carer Name: |  | | | **GP Surgery:** |  | | | | | |
| Patient meets the Level 3 criteria because: | Long term condition or secondary care | ☐ | Pregnant or Breastfeeding partner/family | | ☐ | High prevalence communities | | | | ☐ |
| Under the age of 21 | ☐ | Mental health condition | | ☐ | Routine and manual workers | | | | ☐ |
| Referrer Name: |  | | | **Referral Job Title:** |  | | | | | |
| Referring Organisation: |  | | | **Referral Date:** |  | | | | | |

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| Consent: | |
| I confirm that the patient has agreed to share their data with Everyone Health’s Enfield Stop Smoking Service | |
| Referrer’s Name: | **Referrer’s Signature:** |

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| --- | --- | --- |
| Please send completed referral form via post, fax or e-mail as below | | |
| Address:  Clinical Contact Centre  3 Watling Drive,  Sketchley Meadows,  Hinckley,  LE10 3EY | **Fax:**  0208 181 6301 | **Email:**  Clinical.contactcentre@nhs.net |
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