



**Cumbria Stop Smoking Service
Referral to the Stop Smoking Service**

NHS Number: _____

Client Name: _____ Date of Birth: _____

Address: _____

_____ Post Code: _____

Telephone Numbers :

Home: _____ Mobile: _____ Work: _____

Is it OK to leave messages on this/these numbers? YES/NO

How did you hear about the service? _____

Email address: _____

Preferred call back time: _____

Exempt from Prescription charges: YES/NO Pregnant: YES/NO

GP Name & Address : _____

Do you consider yourself to have a physical disability? YES/NO

If so, please let us know to what extent (ie. wheelchair user etc.) _____

CLIENT CONSENT: I agree to be referred to the Stop Smoking Service for advice and support in stopping smoking and I understand I will be contacted as soon as possible

Client Signature: _____ Date: _____

Referred by: _____ Date Referred: _____

Professional Status/Ward/Dept: _____ Contact No: _____

Please return to:-
Cumbria Stop Smoking Service
Ann Burrow Thomas Health Centre
South William Street
WORKINGTON
Cumbria, CA14 2EW

OR FAX to the Booking Centre on 01228 603564