Tobacco Dependence Clinic
Client Referral Form

Date _____ /_____ / _____ Referral Source _____
d m y

Client Last Name _____ **First Name** _____

PARIS ID # _____ Date of Birth _____ /_____ /_____ Age _____
d m y

Gender M ☐ F ☐ Transgender ☐ If female, pregnant? Y ☐ N ☐

Breastfeeding? Y ☐ N ☐

Home Address _____
Postal Code

Home Phone _____ Message OK? Y ☐ N ☐

Emergency Contact _____
Name and Relationship Phone

VCH Mental Health Team client? _____
MH Team, Team Physician, and / or Case Manager

VCH Addiction Services client? _____
Addiction Physician, Addiction Nurse, Addiction Counsellor and / or Clinic

Primary health care provider _____
Physician, Nurse Practitioner, and / or Clinic Name

Has client ever attended TDC or Butt Out group: Y ☐ N ☐ Dates _____

Is client prepared to attend group at a location other than with own MH Team? Y ☐ N ☐

Mental health / Substance use diagnoses: _____

_____

Medications (attach list if necessary)	**Dose and Route**	**Frequency**

Fax completed form to: