Smoking Advice Service Self-Referral

ONCE COMPLETED – POST IN COLLECTION BOX AT RECEPTION

For office use only:
CLEINT ID

NHS Grampian

Name:
DOB: Gender: ☐ M ☐ F
Last 4 digits of CHI Number (if known)
Full Address:

Postcode:
Home Tel:
Mobile Tel:

Registered GP Practice:
MORAY COAST MEDICAL PRACTICE
MUIRTON ROAD
LOSSIEMOUTH
MORAY
IV31 6TU

If female, are you pregnant?
Pregnant?
☐ Yes ☐ No Planning ☐

Do you receive free prescriptions?
☐ Yes ☐ No

Have you signed up for the Smoke Free Homes & Cars Campaign?
☐ Yes ☐ No

WHICH OF THE FOLLOWING BEST DESCRIBES YOUR ETHNIC ORIGIN?
(Choose one section from A-F, and then tick one box only within that section)

A White
- ☐ Scottish
- ☐ British
- ☐ Irish
- ☐ Any other white background (please specify) _____

B Mixed background
- ☐ White and black Caribbean
- ☐ White and black African
- ☐ White and Asian
- ☐ Any other mixed background (please specify) _____

C Asian, Asian Scottish or Asian British
- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Any other Asian background (please specify) _____

D Black, black Scottish or black British
- ☐ Caribbean
- ☐ African
- ☐ Any other black black background (please specify) _____

E Any other ethnic group_____

F Do not wish to disclose ☐

EMPLOYMENT STATUS (Please tick one box)
- ☐ In paid employment
- ☐ Full-time student
- ☐ Homemaker, full-time parent or carer
- ☐ Unemployed
- ☐ Retired
- ☐ Permanently sick or disabled
- ☐ Self-employed
- ☐ Other - please specify_____

TOBACCO USE AND QUIT ATTEMPTS

When do you smoke your first cigarette?
- ☐ within 5 minutes of waking
- ☐ 6-30 minutes
- ☐ 31-60 minutes
- ☐ After 60 minutes

How many do you smoke each day?
- ☐ 10 or less
- ☐ 11-20
- ☐ 21-30
- ☐ more than 30

Have you tried to quit smoking in the past year?
- ☐ No. No quit attempt
- ☐ Yes. Once
- ☐ Yes. 2-3 times
- ☐ Yes. 4 or more times

SMOKING CESSATION SERVICE CONSENT

Are you happy for us to contact you in the future about this attempt to stop smoking? ☐ Yes ☐ No

Personal information will be held in accordance with the Data Protection Act (1988) and will only be used for the purpose of providing the necessary advice and services to you.

Name:_____ Signature: _____ Date:_____

TO BE COMPLETED BY THE HEALTH PROFESSIONAL MAKING THIS REFERRAL

Referral category: ☐ Routine ☐ Keep well ☐ Clinical need ☐ Pre-operative

Name:_____ Signature: _____

Job title:_____ Name:_____

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Base, location or practice stamp.