|  |  |  |
| --- | --- | --- |
|  | **Specialist Stop Smoking Support** **Referral** |  |

***Please complete and email to:*** [***yorwellbeing@york.gov.uk***](mailto:yorkwellbeing@york.gcsx.gov.uk)

**Client details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Full Name: |  | | Date of birth: |  |
| Ethnicity: |  | | Gender: |  |
| Address: |  | | | |
|  | | | Postcode: |  |
| Mobile phone number: | |  | | |
| Land line number: | |  | | |
| GP Practice: | |  | | |

**Please indicate which health conditions apply**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Asthma |  | Cancer |  | Heart Disease |  |
| COPD |  | Mental Health |  | Diabetes |  |
| Pregnancy |  | Stop B4 your Op |  | Other (please state) |  |

**Referred by (please enter name)**

|  |  |
| --- | --- |
| Midwife |  |
| GP practice |  |
| Hospital |  |
| Other *(please state)* |  |

**Please use this space for any information about the smoker that you feel is important to know Including accessibility needs.**