Fax Referral Sheet

To: **Quitline (Victoria)** **Fax:** 1800 931 739

Patient information – *confidential*

** mandatory fields*

***First name:** ..... ***Last name:** .....

***Preferred phone no:** .....

Does the patient identify as being Aboriginal or Torres Strait Islander?

☐ Yes ☐ No ☐ Unknown

What is the best time to call? ☐ Morning ☐ Midday ☐ Afternoon

Is it OK for the Quitline to leave a message? ☐ Yes ☐ No

Please note: We will attempt to contact you within your requested time block, however this may not always be possible.

Referrer details

** mandatory fields*

***First name:** ..... ***Last name:** .....

***Organisation:** .....

***Email:** .....

***Phone:** .....

Fax Referral Sheet

Referrer Details (cont'd)

Please select the most appropriate setting

Sector	Setting	
Aboriginal organisation	Aboriginal health worker	☐
	General or nurse practitioner	☐
	Health promotion worker	☐
	Koori maternity worker	☐
	Nurse	☐
	Oral health professional	☐
	Pharmacist	☐
	Psychologist/counsellor	☐
	Tackling indigenous smoking worker	☐
	Other allied health	☐
Alcohol and other drugs	Care and recovery coordination	☐
	Counselling	☐
	Intake	☐
	Needle and syringe program	☐
	Peer support	☐
	Therapeutic rehabilitation	☐
	Withdrawal	☐
Mental health	Acute community	☐
	Acute inpatient	☐
	Mental health community support service	☐
	Specialist mental health	☐
	Subacute community	☐
	Subacute residential	☐

Sector	Setting	
Hospital/health service	Cardiology	☐
	Emergency	☐
	Maternity	☐
	Mental health	☐
	Oncology	☐
	Pharmacy	☐
	Rehabilitation	☐
	Respiratory	☐
	Surgery	☐
	Other	☐
Primary and community health	Community pharmacist	☐
	General or nurse practitioner	☐
	Maternal and child health	☐
	Nurse	☐
	Oral health professional	☐
	Psychologist/counsellor	☐
	Other allied health	☐
Social and community services	Aged care	☐
	Disability service	☐
	Family violence service	☐
	Financial advice/counselling	☐
	Gambling support	☐
	Housing/homelessness	☐
	Prisoner/former prisoner support	☐
	Youth services	☐
	Other	☐

Please Note: *By submitting this referral you acknowledge that your patient has consented to this information being disclosed.*