

Be Smoke Free Manchester

If you are making this referral on behalf of someone else, please ensure they have consented to receive support to stop their tobacco use.

Date of referral:

Email: manchesterbesmokefree@cgl.org.uk

REFERRAL

Forename: Surname:

Date of Birth:

Gender: Ethnicity:

Home Address:

Post code:

Phone number: Home: Mobile:

Email:

Preferred Language Interpreter Required Yes ☐ No ☐

TRIAGE ASSESSMENT

Due to Covid-19, we are currently prioritising telephone support for those who have the most urgent need. In order of us to do this, please answer the below questions.

Do you have a mental health problem? Yes ☐ No ☐

Do you have respiratory problems? E.g COPD, asthma, emphysema Yes ☐ No ☐

Are you pregnant? Yes ☐ No ☐

Are you over the age of 60? Yes ☐ No ☐

Risk issues (mental health, physical health, pregnancy, safeguarding)

CONSENT

We are bound by laws, regulations and organisational values which inform how we use any information about you. We will not share information without your consent. To ensure that we can offer and remind you of appointments with Change Grow Live, we require permission to contact you. If you use the internet, we encourage you to consent to email contact so we can send you online resources. Please tick all your preferred contact methods;

Phone ☐ Voicemail ☐ SMS ☐ Email ☐ Write ☐ Contact GP ☐

STAFF USE ONLY

Outcome of referral
 Email resource pack ☐
 Telephone assessment booked ☐
 Declined telephone assessment ☐
 Contact for face to face intervention when available? ☐
 Declined further input ☐

Additional Information

Form completed by