



**STOP SMOKING SERVICE  
 SELF REFERRAL – GROUP  
 College Lane Surgery  
 Barnsley Road  
 Ackworth  
 WF7 7HZ  
 Tel: 01977 611023**



*For Office Use Only*

Has client completed all questions asked    Yes        No   

Date of 1<sup>st</sup> intervention [ / / ]    Quit date [ / / ]    Product Used \_\_\_\_\_    Successful at four weeks    Yes        No   

**Please fully complete this form as soon as possible and return it to the address above.**

Name \_\_\_\_\_ Male  Female

Address \_\_\_\_\_

Post Code \_\_\_\_\_ Day/Evening Tel No. \_\_\_\_\_

Date of Birth \_\_\_\_\_ Mobile Tel No. \_\_\_\_\_

Do you suffer from any allergies    Yes     No     If yes, please state these allergies below

\_\_\_\_\_

\_\_\_\_\_

Are you pregnant    Yes     No     If yes, due date \_\_\_\_\_

Next of Kin \_\_\_\_\_ Religion \_\_\_\_\_

**Ethnic group**

WHITE	MIXED	ASIAN	BLACK	OTHER
British <input type="checkbox"/>	White/Black Caribbean <input type="checkbox"/>	Indian <input type="checkbox"/>	Caribbean <input type="checkbox"/>	Chinese <input type="checkbox"/>
Irish <input type="checkbox"/>	White/Black African <input type="checkbox"/>	Pakistani <input type="checkbox"/>	African <input type="checkbox"/>	Other ethnic _____
Other white <input type="checkbox"/>	White/Asian <input type="checkbox"/>	Bangladeshi <input type="checkbox"/>	Other black <input type="checkbox"/>	Please state which _____
	Other mixed _____	Other Asian <input type="checkbox"/>		
	Please state which _____			

GP/Consultant Name \_\_\_\_\_

Telephone Number \_\_\_\_\_

Address \_\_\_\_\_

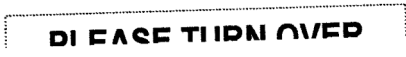
**COLLEGE LANE SURGERY STOP SMOKING GROUP IS HELD ON A TUESDAY AFTERNOON 4PM – 5PM**  
**Would you like to attend this session? YES / NO Please circle your choice.**

Please state the appointment time you would prefer with the Stop Smoking Service.    Morning     Afternoon     Evening   
 (9am to 1pm)    (1pm to 4pm)    (6pm to 7pm)

This may be offered at another venue in the area.  
 If cannot attend sessions at certain times please note \_\_\_\_\_

How did you find out about this service    GP     Friend     Family     Midwife

Health Visitor     Advertisement     Workplace     [ ] Other \_\_\_\_\_





How many cigarettes do you smoke per day \_\_\_\_\_

Do you smoke within twenty minutes of waking Yes [ ] No [ ]

Would the first cigarette of the day be the hardest to give up Yes [ ] No [ ]

Do you smoke more in the morning than the rest of the day Yes [ ] No [ ]

Have you tried to stop in the last Ten years Yes [ ] No [ ]

If yes, how many times \_\_\_\_\_ how long did you stop for on the last occasion \_\_\_\_\_

In the past year have you reduced the number of cigarettes you smoke in one day Yes [ ] No [ ]

What is the main reason for quitting smoking \_\_\_\_\_

Please state any medical conditions and medications

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you interested in any particular aids to help you stop smoking, if so please state which ones

\_\_\_\_\_  
\_\_\_\_\_

All places are offered with the understanding that all clients are willing and committed to attend several sessions

Please sign if you wish to access support from the Specialist Service, and you agree to be contacted by telephone. Feedback on your progress will be passed to your health provider.

Signature \_\_\_\_\_

Date \_\_\_\_\_

