Sunnybrook
HEALTH SCIENCES CENTRE

Rapid Access Addiction Medicine Clinic
Frederick W. Thompson Anxiety Disorders Centre
DEPARTMENT OF PSYCHIATRY
Sunnybrook Health Sciences Centre
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REFERRAL FORM
Smoking Cessation Group

Client Name: DOB:

Health Card or MRN:

Patients phone number:

Patient's Email:

Does the patient consent to leaving a voicemail?

Emergency contact name:

Emergency contact phone number:

Does the patient have access to technology to use zoom

Is there any medical or mental health diagnosis that may impact the patient participating in group? If yes, please explain:

Is the patient followed by the Odette Cancer Center? Y/N
If no, which department is making this referral? _____