# SMOKING CESSATION REFERAL

**Please FAX to: (650) 994-4601**
**Phone: (650) 994-5868**

**Date:** _____________
**Referral Agency/Contact:** ______________________ **Phone #:** ________________

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**Client's Name:** ____________________________**Date of Birth:** ________________
**Address:** ______________________________ **Apt. #**___________
**City**__________________________________ **Zip**__________________
**Phone #: (h)** _______________ **(c)** _______________ **Email:** __________________

**Please check appropriate box for the following:**

**Sex:** □ Male □Female **Language preferred:** _________________

**Race/Ethnicity:**

□ Hispanic/Latino (Specify: ___________)
□ Asian/Asian American (Specify: ___________)
□ Pacific Islander (Specify: ___________)
□ Other (Specify: ___________)
□ White/Caucasian/Non-Hispanic
□ Black/African American
□ Alaskan Native/American Indian
□ Multiracial (Specify: ___________)

□ **Adult Smoker (Over 18yrs.)** □ **Interest in quit class & free nicotine patches**

□ **Pregnant or live w/a pregnant woman** □ **Parenting or living w/children**

**How/where did you find out about the program?**
______________________________________________________________________

**Other Comments/Questions:**
______________________________________________________________________
______________________________________________________________________

I understand that my smoking status may be shared with other providers to ensure the quality of the services I receive. I understand that the service of Breathe California's Ash Kickers Program is not a healthcare service and will consult with my doctor if I have any medical questions.

**Client Signature:** ______________________________ **Date:** ___________________

*Breathe California's*
**Ash Kickers™**
**Smoking Cessation Program**

Funded through grants from the
Tobacco Prevention Program of the
San Mateo County Health Department