

Parent Survey

(Fax Referral)



This survey should be completed by a **parent/guardian of children** attending this visit. **PLEASE PRINT**

Child's Name _____ Child's Date of Birth ____/____/____
Month Day Year

Parent/Guardian's Name _____
First Middle/Second Last

Relationship to Child Mother Father Other (Specify) _____

Your Date of Birth ____/____/____ Language Preference (circle)
Month Day Year
 English Spanish Cantonese Korean Mandarin Vietnamese

Address _____ City _____ Zip Code _____

Home Telephone (____) _____-____-____ Alternate Telephone (____) _____-____-____

Today's Visit 6-Month Well Child Visit Other _____

1. Have you smoked a cigarette, even a puff, in the last 7 days? Yes_(ETS) No_(NS) **(If NO, skip to question #3)**

2a. If help is provided, would you like to quit in the near future? Yes_(S) No_(S-NR)

2b. If yes, please check the best time for a smoking cessation counselor to reach you by phone.
 Mornings 7am-12pm Saturday 9am-1pm
 Afternoons 12pm-5pm Anytime
 Evenings 5pm-9pm

3. Has anyone who lives in your household (**not including you**) smoked a cigarette, even a puff, in the last 7 days? Yes_(ETS) No_(NS)

I acknowledge that the information on this survey may be shared to provide on-going treatment and/or treatment options for smoking cessation. A counselor with the California Smokers' Helpline may contact me to ask if I would like to join a stop smoking program. The counselor may then share information with my child's doctor. I understand that signing my name below will in no way change the care I receive from my doctor.

SIGNATURE _____

DATE ____/____/____
Month Day Year

FOR OFFICE USE	1. Please review survey and determine if a fax referral is needed or education materials should be provided: (S)=Fax Referral (ETS)=Education Materials 2. Please fax referrals (S) to: (858) 300-1136 3. Please place completed survey inside her/his child's chart	For additional materials Please visit our website www.sdSmokeFreeFamilies.com
	<div style="border: 1px solid black; padding: 5px;"> <p style="text-align: center;">OFFICE NAME AND ADDRESS</p> <p style="text-align: center;">Scripps Coastal Medical Center-Hillcrest 501 Washington Street, Suite 600 San Diego, CA 92103</p> <p style="text-align: center;">Clinic ID #28</p> </div>	

Fax Referral (858) 300-1136

Faxed by _____ Date _____

