

# 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<sub>(ETS)</sub>  No<sub>(NS)</sub> **(If NO, skip to question #3)**

2a. If help is provided, would you like to quit in the near future?  Yes<sub>(S)</sub>  No<sub>(S-NR)</sub>

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<sub>(ETS)</sub>  No<sub>(NS)</sub>

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

<b>FOR OFFICE USE</b>	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: <b>(858) 300-1136</b> 3. Please place completed survey inside her/his child's chart	<b>For additional materials</b> Please visit our website <a href="http://www.sdSmokeFreeFamilies.com">www.sdSmokeFreeFamilies.com</a>
	<div style="border: 1px solid black; padding: 5px;"> <p style="text-align: center;"><b>OFFICE NAME AND ADDRESS</b></p> <p style="text-align: center;">PHN South Region Public Health Center            690 Oxford Street            Chula Vista, CA. 91911</p> <p style="text-align: center;">Clinic ID #305</p> </div>	

**Fax Referral (858) 300-1136**

Faxed by \_\_\_\_\_ Date \_\_\_\_\_

