## **SMOKING REVIEW**

**If you have been advised by the surgery to submit an annual review of your asthma symptoms please use this form. If your symptoms are deteriorating or you are having any concerns please make an appointment with our Nurse.**

**Personal Details (fields marked with a red asterisk are compulsory)**

**Name \*** …………………………………………………………………………………………………………………………………………………………………. **Date of Birth (DD/MM/YYYY) \*** …………………………………………………………………………………………………………………………………………………………………. **Daytime Telephone** \* …………………………………………………………………………………………………………………………………………………………………. **Email (by providing your email address we assume consent to reply via email when necessary. If you prefer not to receive email, please alert the surgery)\*** …………………………………………………………………………………………………………………………………………………………………. **Gender**

………………………………………………………………………………………………………………………………...................................

**Postcode \*** ………………………………………………………………………………………………………………………………………………………………….

**Your Smoking Review**

**What is your smoking status? SMOKER/EX-SMOKER/NEVER SMOKED**

**Do you want to quit? YES (you will be contacted by the healthcare assistant)/ NO**

**When did you quit? ………………………………………………………………………………………**

***Privacy Protection***

*Information submitted through secure forms is used only for the purposes of processing your request. We may be in touch with you in relation to the information submitted.*

*All information submitted through secure forms is secured with a private key known only to the GP practice and is accessed over a secure connection by nominated practice staff. Our practice has a strict confidentiality policy.*

*This information is not shared with any third party organisations. This information is retained for up to 28 days.*

*Learn more about our*[*Privacy Policy*](https://www.drdeweeverandpartners.co.uk/Privacy)*and*[*Terms of Use*](https://www.drdeweeverandpartners.co.uk/disclaimer)*. Should you have any concerns about sending your personal details using the web, please use one of the alternative methods offered by our organisation.*

**I consent to my information being used for the purposes described above and wish to submit this online form to Partington Family Practice, Central Road, Partington, Manchester, M31 4FY.**

**SUBMIT**

**If you have any queries, please contact us:**

**Partington Family Practice, Central Road, Partington, Manchester M31 4FY.**

**Tel: 0161 775 7033 Fax: 0161 775 8411**

**Email:**[**clinical.partingtonfamily@nhs.net**](mailto:clinical.partingtonfamily@nhs.net)**​​ Twitter: @PartingtonFP**