Quit The Smoke Registration

Starting date (with/without medication): _____

Please complete the form and have it signed by your doctor. Fax to: 061 287 6071

First Name	
Surname	
Occupation	
Date of Birth	
Medical Aid No.	
Mobile No.	
Telephone No. (H)	
Telephone No. (W)	
E-mail	

How many cigarettes do you smoke per day ? *(Indicate with an "X")*

☐ Less than 10 per day ☐ 20 to 30 per day

☐ 10 to 20 per day ☐ 30+ per day

For how many years have you smoked? _____

Are you suffering from any of the following chronic conditions:
(Indicate with an "X")

☐ High Cholesterol ☐ Diabetes

☐ High Blood Presssure ☐ Cardio Vascular Disease

☐ Gout ☐ Obesity

If yes to any of the above, please list medication: _____

Alcohol consumption:	☐ <1unit/week	☐ 1-4 units/week	☐ 4-8 units/week	☐ >8 units/week
Stress levels:	☐ Low	☐ Medium	☐ High	
Exercise:	☐ Never	☐ <1hr/week	☐ 1-3 hrs/week	☐ >3 hrs/week
Eating Habits:	☐ Poor	☐ Good	☐ Excellent	

If you opt to use the IQS therapy (which involves electrical impulse therapy), you should make contact with them at www.iqsnamibia.com, their representive must sign the form (instead of the doctor) and mail it back to the Wellness Department.

Please Note:

- A copy of the prescription for either ZYBAN or CHAMPIX needs to accompany this registration form.
- After 3 months, you will have to undergo a blood cotinine test at Pathcare (claimable from your day-to-day benefit).
- If the test result is negative, the fund will re-imburse you 100% of cost the ZYBAN/CHAMPIX medication.
- 50% of the cost of the IQS treatment.

NB: You have to submit your claim within 4 months after commencement of treatment. Very important: you must submit a detailed invoice for the purchase of the medication including proof of payment and a copy of the prescription for either ZYBAN or CHAMPIX.

I, _____declare that the above information is correct.

Doctor/IQS Representative Signature _____ **Patient's Signature** _____