Quitline FAX Referral Form

Fax Number: 1-800-483-3114

PROVIDER INFORMATION: **Fax Sent Date: _____ / _____ / _____**

Clinic Name: _____

Health Care Provider: _____

Contact Name: _____

I am a HIPAA-Covered Entity (Please check one) ____Yes ____No ____I Don't Know

Fax: (_____) _____ – _____ **Phone (_____) _____ – _____** **Zip _____**

Comments: _____

PATIENT INFORMATION: **Gender: male / female** **Pregnant? Y N**

Patient Name: _____ **DOB: _____ / _____ / _____**

Address: _____ **City:** _____ **Zip:** _____

Primary #:(_____) _____ – _____ **Type: ____HM ____WK ____CELL ____OTHER**

Secondary #:(_____) _____ – _____ **Type: ____HM ____WK ____CELL ____OTHER**

Language Preference (check one): ____English ____Spanish ____Other – _____

Tobacco Type (check ALL that apply): ____Cigarettes ____Smokeless Tobacco ____Cigar ____Pipe

_____ I am ready to quit tobacco and request the Quitline contact me to help me with my quit plan.
(Initial)

_____ I **DO NOT** give my permission to the Quitline to leave a message when contacting me.
(Initial)

Patient Signature: _____ **Date: _____ / _____ / _____**

The Quitline will call you. Please check the BEST 3-hour time frame for them to reach you. NOTE: The Quitline is open 7 days a week; call attempts over a weekend may be made at times other than during this 3-hour time frame.

☐ **6am - 9am** ☐ **9am - 12pm** ☐ **12pm - 3pm** ☐ **3pm - 6pm** ☐ **6pm - 9pm**

Within this 3-hour time frame, please contact me at (check one): ____Primary ____Secondary

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