



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 (____) _____ - _____

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