PATIENT FAX REFERRAL FORM

Today's Date _____

Referral Form
Fax to: 1-800-261-6259

Use this form to refer patients who are ready to quit tobacco to the Idaho Quitline.

PROVIDER(S): Complete this section

Provider name | Contact Name

Clinic/Hosp/Dept | E-mail

Address | Phone ( ) -

City/State/Zip | Fax ( ) -

Does patient have any of the following conditions: ☐pregnant ☐uncontrolled high blood pressure ☐heart disease

If yes, please sign to authorize the Tobacco Quitline to send the patient free, over-the-counter nicotine replacement therapy if available. If provider does not sign and the patient has any of the above listed conditions, the Quitline cannot dispense medication.

Provider Signature

Please Check: ☐ Patient agreed with clinician to be referred to the Tobacco Quit Line.

PATIENT: Complete this section

_____ *Initial* Yes, I am ready to quit and ask that a quit line coach call me. I understand that the Tobacco Quitline will inform my provider about my participation.

Best times to call? ☐morning ☐afternoon ☐evening ☐weekend

May we leave a message? ☐Yes ☐No

Are you hearing impaired and need assistance? ☐Yes ☐No

Date of Birth? / / Gender ☐M ☐F

Patient Name (Last) (First)

Address City State

Zip Code E-mail

Phone #1 ( ) - Phone #2 ( ) -

Language ☐English ☐Spanish ☐Other

Patient Signature Date

PLEASE FAX TO: 1-800-261-6259

Or mail to: Tobacco Quit Line., c/o National Jewish Health®, 1400 Jackson St., S117A, Denver, CO 80206