



**TOBACCO  
REDUCTION  
AND  
PREVENTION**

**PATIENT FAX REFERRAL FORM**

**Fax to: 1-800-261-6259**

Today's Date \_\_\_\_\_

Use this form to refer patients who are ready to quit tobacco in the next 30 days to the Michigan Tobacco 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 Michigan 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 Michigan Tobacco Quitline cannot dispense medication.

Provider Signature \_\_\_\_\_

Please Check:  Patient agreed with clinician to be referred to the Michigan Tobacco Quitline.

**PATIENT: Complete this section**

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

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: Michigan Tobacco Quitline., c/o National Jewish Health®, 1400 Jackson St., S117A, Denver, CO 80206

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