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.

Person who receives patient feedback or who can clarify patient contact information. This may be the provider or could be the receptionist, nurse or medical records staff.

PROVIDER(S): Complete this section

Provider name (Physician, PA, Nurse, Health Educator, Etc.) Contact Name

Clinic/Hosp/Dept

E-mail (Optional)

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.

You do not need to fill out this section unless the patient is pregnant or has high blood pressure or heart disease and wants NRT. Patients with these conditions who want NRT must have the form signed by a provider licensed to prescribe in the State of Michigan..

Provider Signature

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

Check this box if your client agreed in person or by phone.

PATIENT: Complete this section

_____ *Initial* 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.

Note here if patient agreed by phone.

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 (Optional)

Phone #1 ( ) *REQUIRED. Must be able to contact by phone. 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