Fax-to-Quit

Fax Referral Form

Fax form to: 1-866-QUIT-FAX

FtQReferForm08-25-06.doc **(1-866-784-8329)**

Patient stamp, label OR Name, record number, DOB, date:

TOBACCO TREATMENT CHECKLIST

ADVISE smoker to stop smoking. Recommended stop-smoking advice: ***"I strongly advise you to quit smoking and can help you."***

ASSESS readiness to quit: ☐ Ready to quit ☐ Thinking about quitting ☐ Not ready to quit

ASSIST smoker to quit: ☐ Brief counseling ☐ Medications if appropriate:

Nicotine Replacement (CIRCLE): patch gum lozenge inhaler nasal spray

Other (CIRCLE): bupropion (Zyban® or wellbutrin SR®) varenicline (Chantix™)

ARRANGE follow-up: ☐ Refer to NYS Smokers' Quitline by faxing this page (toll-free) to **1-866-QUIT-FAX (1-866-784-8329)**

REFERRAL SOURCE

Referred by:

Name (Please print) _____

Institution/Organization _____

Address _____

City/State/Zip Code _____

Phone (area code + number)

( ) _____ - _____

Fax (area code + number)

( ) _____ - _____

DO NOT CALL PATIENT UNTIL AFTER (mm/dd/yy):

_____ / _____ / _____

Send progress report to (If different from above):

Name (Please print) _____

Institution/Organization _____

Address _____

City/State/Zip Code _____

Phone (area code + number)

( ) _____ - _____

Fax (area code + number)

( ) _____ - _____

PATIENT INFORMATION

Patient's name (Please print)

First: _____ Last: _____

Date of Birth (mm/dd/yy):

_____/_____/_____

Phone number (including area code): ( ) _____ - _____

May we leave a message? ☐ **Yes** ☐ **No**

Best time to call: ☐ **Morning** (9 am to noon) ☐ **Afternoon** (Noon to 5 pm) ☐ **Evening** (5 pm to 9 pm)

Language: ☐ **English** ☐ **Spanish**

Other: _____

Street Address: _____

City: _____ **Zip Code:** _____

Health Insurance? ☐ **Yes** ☐ **No**

E-mail: _____

@ _____ . _____

Insurance carrier: _____

If Medicaid, ID Number: _____

PERMISSION

I (undersigned) give permission for the support staff of the New York State Smokers' Quitline to contact me, coach me in quitting smoking, and give feedback regarding my progress to the health care provider listed above and permission for that provider to forward the information to other relevant health care providers.

_____ _____/_____/_____

Signature of Patient (or Agent if authorization was verbal). Signature is required for patient to be called. **Date**