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

_____ *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.

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