



**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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