

Fax-to-Quit**Fax Referral Form**

Fax form to: **1-866-QUIT-FAX**
(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 Prescription medications if appropriate:
- Nicotine Replacement (CIRCLE): patch gum lozenge inhaler nasal spray
- Other (CIRCLE): bupropion (Zyban® or Wellbutrin SR®)
- ARRANGE** follow-up: Refer to NYS Smokers' Quitline by faxing this page (toll-free) to **1-866-784-8329**

REFERRAL SOURCE

Referred by:	Name (Please print) _____	Phone (area code + number) () _____ - _____
	Group/Agency/Hospital/Organization _____	Fax (area code + number) () _____ - _____
	Street Address/City/State/Zip Code _____	DO NOT CALL PATIENT UNTIL AFTER (mm/dd/yy): _____ / _____ / _____

Send progress report to (If different from above):

Name (Please print) _____	Phone (area code + number) () _____ - _____
Group/Agency/Hospital/Organization _____	Fax (area code + number) () _____ - _____
Street Address/City/State/Zip Code _____	() _____ - _____

PATIENT INFORMATION

Patient's name (Please print)		Date of Birth (mm/dd/yy):
First: _____	Last: _____	_____ / _____ / _____
Phone number (including area code): () _____ - _____		May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No
Best time to call: <input type="checkbox"/> Morning (9 am to noon) <input type="checkbox"/> Afternoon (Noon to 5 pm) <input type="checkbox"/> Evening (5 pm to 9 pm)		Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish
Street Address: _____		Other: _____
City: _____	Zip Code: _____	Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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**