

# Patient Referral Form (Fax to Quit)

Please only refer patients/clients who currently use commercial tobacco, such as cigarettes or vape products.

Fax the completed form to 1-866-QUIT-FAX (1-866-784-8329).

## Referral Consent and Date

Please select the following to confirm patient/client consent.

- I agree that my patient/client has provided written or verbal consent to refer their information, agrees to be contacted by the NYS Quitline, and allows the designated healthcare professional to receive outcome reports from the Quitline. And that this verified consent is on file with this healthcare professional.

Today's date: \_\_\_/\_\_\_/\_\_\_\_\_

## Patient/Client Information

Please complete the following information on behalf of your patient/client.

First and Last Name \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_/\_\_\_/\_\_\_\_\_

Patient/client's contact details (phone required)

Primary Phone \_\_\_\_\_

E-mail Address \_\_\_\_\_

Is the phone number provided a landline or mobile number?

- Mobile phone  
 Landline

Patient/client's preferred time to be contacted:

- Morning  
 Afternoon  
 Evening  
 No preference

Does the patient/client agree to receive voicemail, text messages, or email?\* Please select all that apply.

- Yes (voicemail, text, and/or email)  
 Voicemail  
 Text messages  
 Email  
 No, the patient/client does not want to receive any of these

\*The question above regards consent to leave voice or text messages with your patient/client. The NYS Quitline contacts a selection of participants to ask for feedback, provide shipping notifications and additional medications, and to let them know about new services. Patients/clients may opt-out at any time by calling us or by texting "STOP2END" to unsubscribe, "RESTART" to resubscribe, and "INFO" for information about this program. Message and data rates may apply.

## Healthcare Professional/Organization Information

The following information is required to complete your patient/client referral.

First and last name \_\_\_\_\_

Organization/Program/Site Name \_\_\_\_\_

\_\_\_\_\_

Send my patient/client progress report via secure:

Web access\*

Email (Attachment)\*

Fax (Provider Secured)

Do not send a progress report

**\*If you've selected web access or email (attachment) above, please provide your email:**

Email \_\_\_\_\_

**FOR NEW REFERRING PHYSICIANS ONLY:**

**Organization/Program/Site Name Information:**

Street \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip code \_\_\_\_\_

**How would you like to be contacted by the NYS Quitline?**

Email\*

Call\*

Text message\*

Doesn't matter

Do not contact me

**\*Please provide the information selected here:**

Email \_\_\_\_\_

Phone number \_\_\_\_\_