

Refer-to-Quit Referral Form

Patient stamp, label, OR info (name, record number, DOB, date):

Fax form to: 1-866-QUIT-FAX (1-866-784-8329)

Step-by-Step:

- If a tobacco user would like help from the Quitline, complete form.
- Fax completed form to 1-866-784-8329.
- A Quitline Quit Coach will contact the tobacco user and offer free cessation services. A progress report will be sent to the provider listed on this form.
- The Quitline program is a free service for all New York State residents regardless of insurance status.

Code: **TCPPF**
Special Programs Only

Tobacco Users: Complete This Section

(Please print)

_____ Date of Birth
 First Name Last Name _____ / _____ / _____

_____ City State Zip Code
 Mailing Address

Male Female Gender () _____ - _____ Primary Phone (area code + number) () _____ - _____ Secondary Phone (Area code + number)

E-mail Address: _____

When should we call? Morning Afternoon Evening No preference May we leave a message? Yes No

Language Preference: English Spanish Other (specify) _____

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 below and permission for that provider to forward the information to other relevant health care providers.

_____ Date
Required Tobacco User's Signature (or agent if authorization was verbal)

Health Providers/Employer/Other: Complete This Section

_____ () _____ - _____
 Referrer: Phone number

_____ () _____ - _____
 Facility: Fax number

_____ City State Zip
 Address:

E-mail address: _____

SEND PROGRESS REPORT VIA SECURED: Secured Site Access E-mail (Secured Attachment)
 Fax (Provider Secured) DO NOT SEND PROGRESS REPORT

If a selection is not indicated, no progress reports will be made available.

Send feedback report to:

Same as above or _____ () _____ - _____
 Name Phone number

_____ () _____ - _____
 Facility Fax number

E-mail address: _____

PEDIATRICS ONLY: Tobacco Users' relationship to child: Mother Father Other (specify) _____
 Child/Children's name: (to help with recordkeeping) _____