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: **MOQC -** ____________________ E-mail (optional): ____________________

Address: ____________________ Phone: ____________________

City/State/Zip: Mt Pleasant MI ____________________ 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 (for above conditions): ____________________

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 (optional) ____________________

Phone #1 ( ) - ____________________ Phone #2 ( ) - ____________________

Language: ☐English ☐Spanish ☐Arabic ☐Other ____________________

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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