

# FAX REFERRAL FORM

To be contacted by the **Nevada Tobacco Quitline** fax this completed form to: **1-800-261-6259**



## REFERRING ORGANIZATION: Complete this section

Organization/  
Practice \_\_\_\_\_ Contact Name \_\_\_\_\_

Clinic/Hosp/Dept \_\_\_\_\_ E-mail \_\_\_\_\_

Address \_\_\_\_\_ Phone (     )     - \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Fax (     )     - \_\_\_\_\_ *If you do not wish to receive fax-back updates on patient referrals enter **NA** for fax number.*

Referrer Signature \_\_\_\_\_ Date \_\_\_\_\_

Are you a Medical Provider:  Yes  No *If Yes, please provide credentials: \_\_\_\_\_*

Please Check:  Participant agreed to be referred to **Nevada Tobacco Quitline**.

## PROVIDER: Complete this section (only necessary if one of the below conditions exists)

Does patient have any of the following conditions:  Pregnant/Breastfeeding  Uncontrolled high blood pressure  
 Heart disease  Stroke

If yes, please sign to authorize the **Nevada 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 **Nevada Tobacco Quitline** cannot dispense medication.

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

## PATIENT: Complete this section

\_\_\_\_ Yes, I am ready to quit and ask that a coach call me. I understand that the **Nevada Tobacco Quitline** may inform the referring party about my participation.

*Initial* \_\_\_\_\_

Best times to call:  Morning  Afternoon  Evening  Weekend

May we leave a message:  Yes  No

Date of Birth?     /     /     \_\_\_\_\_ Gender  Male  Female

Patient Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ E-mail \_\_\_\_\_

Phone #1 (     )     - \_\_\_\_\_ Phone #2 (     )     - \_\_\_\_\_

Language  English  Spanish  Other \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ Date \_\_\_\_\_

If no patient signature available:  Check to Verify Patient Consent is on File.

The Nevada Tobacco Quitline Program will call you within 24 hours of receiving this referral. The call will come from "800-784-8669". In addition the Quitline is open 7 days a week.

FOR QUITLINE REFERRAL PLEASE FAX COMPLETED FORM TO: **1-800-261-6259**