

# FAX-TO-QUIT REFERRAL FORM

Date \_\_\_\_\_



Use this form to refer patients who are ready to quit tobacco in the next 30 days to the Colorado QuitLine.

## PROVIDER(S): Complete this section

Provider name _____	Contact name _____
Clinic/Hosp/Dept _____	E-mail _____
Address _____	Phone (    )    - _____
City/State/Zip _____	Fax    (    )    - _____

**PLEASE INDICATE IF THE PATIENT HAS MEDICAID:**     YES     NO

If yes, and you are prescribing tobacco cessation medication, please complete the Medicaid prior-authorization form on the back of this form and provide patient with a prescription. All FDA-approved tobacco cessation medications are available.

Does patient have any of the following conditions?

pregnant     uncontrolled high blood pressure     heart disease

**YES**, I authorize the QuitLine to send the patient over-the-counter nicotine replacement therapy.

### Provider signature

A provider signature is required to authorize the QuitLine to dispense nicotine replacement therapy for patients with any of the above conditions.

Comments \_\_\_\_\_

## PATIENT: Complete this section

\_\_\_\_\_  
*Initial*    Yes, I am ready to quit and ask that a QuitLine coach call me. I understand that the Colorado QuitLine will inform my provider about my participation.

Best times to call?     morning     afternoon     evening     weekend

May we leave a message?     Yes     No

Are you hearing impaired and need assistance?     Yes     No

Insurance?     Yes     No

Insurance carrier: \_\_\_\_\_

Member ID: \_\_\_\_\_

Medicaid?     Yes     No

Date of birth:    /    /    Gender     M     F

Patient name (Last) \_\_\_\_\_ (First) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ CO \_\_\_\_\_

Zip code \_\_\_\_\_ E-mail \_\_\_\_\_

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

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

**Patient signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**PLEASE FAX THIS PATIENT FAX REFERRAL FORM TO: 1-800-261-6259**

Or mail to: Colorado QuitLine, National Jewish Health, 1400 Jackson St., M305, Denver, CO 80206

**Confidentiality Notice:** This facsimile contains confidential information. If you have received this in error, please notify the sender immediately by telephone and confidentially dispose of the material. Do not review, disclose, copy or distribute.