Patient ID#

1-800-QUIT NOW
Indiana's Tobacco Quitline

Indiana Tobacco Quitline
CLINIC FAX REFERRAL FORM
FAX 1.800.483.3114

Clinic

Date Fax Sent _____/_____/_____

PROVIDER INFORMATION

Clinic Name_____

Health Care Provider _____

Address _____

City_____ State_____ Zip_____ County_____

I am HIPAA-Covered Entity (check one) ☐ Yes ☐ No ☐ I Don't Know

Fax (_____) _____ - _____ Phone (_____) _____ - _____ email _____

Comments _____

PATIENT INFORMATION

Gender ☐ Male ☐ Female **Pregnant?** ☐ Yes ☐ No

Patient Name_____ Date of Birth _____/_____/_____

Address _____

City_____ State_____ Zip_____ County_____

Primary Phone# (_____) _____ - _____ **TYPE** ☐ Home ☐ Work ☐ Cell ☐ Other

Secondary Phone# (_____) _____ - _____ **TYPE** ☐ Home ☐ Work ☐ Cell ☐ Other

Language Preference (check one) ☐ English ☐ Spanish ☐ Other_____

Tobacco Type (check all that apply) ☐ Cigarettes ☐ Smokeless Tobacco ☐ Cigar ☐ Pipe

_____ (Initial) I am ready to quit tobacco and request the Indiana Tobacco Quitline contact me to help me with my quit plan.

_____ (Initial) I **do not** give my permission to the Indiana Tobacco Quitline to leave a message when contacting me.

Patient Signature _____

The Indiana Tobacco Quitline will call you. Please check the BEST 3-hour time frame for them to reach you.
Note: The Quitline is open 7 days a week; call attempts over a weekend may be made at times other than the selected 3-hour time frame.

☐ 6am-9am ☐ 9am-12pm ☐ 12pm-3pm ☐ 3pm-6pm ☐ 6pm-9pm