

MONTANA TOBACCO



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 Montana Tobacco Quit Line.

PROVIDER(S): Complete this section. (Please print clearly.)

Provider name _____ Contact Name _____

Clinic/Hosp/Dept _____ E-mail _____

Address _____ Phone () - _____

City/State/Zip _____ Fax () - _____

Does patient have any of the following conditions: pregnant uncontrolled high blood pressure heart disease

If yes, please sign to authorize the Montana Tobacco Quit Line 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 Montana Tobacco Quit Line cannot dispense medication.

Provider Signature _____

Please Check: Patient agreed with clinician to be referred to the Montana Tobacco Quit Line

PATIENT: Complete this section. (Please print clearly.)

Initial Yes, I am ready to quit and ask that a quit line coach call me. I understand that the Montana Tobacco Quit Line will inform my provider about my participation.

Best times to call? (Please check all that apply.) morning afternoon evening weekday weekend anytime

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 MT

Zip Code _____ E-mail _____

Phone #1 () - _____ Phone #2 () - _____

Language English Spanish Other _____

Patient Signature _____ Date _____

PLEASE FAX TO: 1-800-261-6259

Or mail to: Montana Tobacco Quit Line., c/o National Jewish Health®, 1400 Jackson St., S117A, Denver, CO 80206

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