IDAHO QUITLINE FAX REFERRAL FORM

Fax Number: 1-800-483-3114

Provider Information:

FAX SENT DATE: _____/_____/_____

CLINIC NAME

CLINIC ZIP CODE

HEALTH CARE PROVIDER

CONTACT NAME

FAX NUMBER

PHONE NUMBER

I AM A HIPAA COVERED ENTITY (PLEASE CHECK ONE)

YES ☐ NO ☐ DON'T KNOW ☐

Patient Information:

PATIENT NAME

DATE OF BIRTH

GENDER

☐ MALE ☐ FEMALE

ADDRESS

CITY

ZIP CODE

PRIMARY PHONE NUMBER

PLEASE CONTACT ME between (CIRCLE one 3 hour timeframe)

☐ **6AM – 9AM** ☐ **9AM – 12PM** ☐ **12PM – 3PM** ☐ **3PM – 6PM** ☐ **6PM – 9PM**

SECONDARY PHONE NUMBER

PLEASE CONTACT ME between (CIRCLE one 3 hour timeframe)

☐ **6AM – 9AM** ☐ **9AM – 12PM** ☐ **12PM – 3PM** ☐ **3PM – 6PM** ☐ **6PM – 9PM**

The Idaho Quitline will call you. ***NOTE: The Quitline is open 7 days a week; call attempts over a weekend may be made at times other than during your 3-hour time frame.***

LANGUAGE PREFERENCE (*PLEASE **CIRCLE** ONE*)

ENGLISH SPANISH OTHER

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

_____ *(Initial)* I **DO NOT** give my permission to the Idaho Quitline to leave a message when contacting me.
***** By not initialing, you are giving your permission for the quitline to leave a message.***

PATIENT SIGNATURE: _____ **DATE:** _____/_____/_____