



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

____ 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.
(Initial) **** By not initialing, you are giving your permission for the quitline to leave a message.**

PATIENT SIGNATURE: _____

DATE: ____/____/____

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