

Mississippi tobaccoQUITLINE 1.800.QUITNOW

1.800.784.8669

Mississippi Tobacco Quitline Fax Referral/Consent Form

Health Care Provider Information – Please Print

Health Care Provider (First Last, Title):

Organization/Clinic Full Name:

Organization: Health Department Hospital Clinic Other

Type of Practice: OB-GYN Family Practice Pediatrics Other

Fax Number: () -

Attention:

Phone: () -

Email:

Have you discussed this tobacco cessation program with this patient? YES NO

May IQH provide nicotine replacement therapy products to this patient? YES NO

Patient Information – Please Print

First Name:

Last Name:

Middle Initial:

Mailing address:

City:

State/Zip:

Phone: () -

E-mail:

May we leave a message: YES NO

Language Preference: English Spanish Other :

The Mississippi Tobacco Quitline Staff can call me during the following times (check all that apply):

7am-10am 10am-1pm 1pm-4pm 4pm-7pm 7pm-9pm

I give my consent for the Mississippi Tobacco Quitline to call me and provide follow-up to my healthcare provider:

_____ (patient signature)

Follow-up Information for Referring Provider:

Internal Use Only: Thank you for your referral to the MS Tobacco Quitline. Please note we make at least 3 attempts to reach a patient for enrollment. Below is the status of your referral:

- | | |
|--|--|
| <input type="checkbox"/> Patient was contacted and has declined services | <input type="checkbox"/> Patient was contacted and registered for counseling |
| <input type="checkbox"/> Patient was not contacted after multiple attempts | <input type="checkbox"/> Patient was contacted and opted to receive information only |

Complete and send to IQH, Mississippi Tobacco Quitline, 385-B Highland Colony Parkway, Suite 504, Ridgeland, MS 39157 or **Complete** and **Fax** this form to: **(601) 899-8650/1-800-692-9023** or **referrals@iqhquitline.com**

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