

Refer-to-Quit

Referral Form

Fax Form to: 1-866-QUIT-FAX (1-866-784-8329)

Step-by-Step

CODE:

Special Programs Only

- If a tobacco user is interested in quitting tobacco use, complete this form.
- Fax completed form to 1-866-784-8329.
- A Quit Coach will contact the tobacco user and offer free cessation services. A progress report will be sent to the provider listed on this form.
- This program is free for all New York State residents regardless of insurance status.

Tobacco Users: Complete This Section

(Please Print)

_____ First Name	_____ Last Name	_____/_____/_____ Date of Birth (mm/dd/yy):
_____ Mailing Address		_____ City
_____ Primary Phone (area code + number)		_____ State
_____ Secondary Phone (area code + number)		_____ Zip Code
		<input type="checkbox"/> Male <input type="checkbox"/> Female Gender
When should we call? <input type="checkbox"/> Morning (9am - Noon) <input type="checkbox"/> Afternoon (Noon-5pm) <input type="checkbox"/> Evening (5pm to 9 pm) <input type="checkbox"/> No preference		
E- Mail Address: _____		
Language Preference: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (specify) _____		

I (undersigned) give permission for the support staff of the New York State Smokers' Quitline to contact me, coach me in quitting smoking, and give feedback regarding my progress to the health care provider listed above and permission for that provider to forward the information to other relevant health care providers.

Required Tobacco User's Signature (or agent if authorization was verbal)

_____/_____/_____
Date

Health Providers/Employer/Other: Complete this section

_____ Referrer First Name - Last Name		(585) 275-7424 Phone (area code + number)	
Strong Internal Medicine U of R Facility		(585) 275-1041 Fax (area code + number)	
601 Elmwood Ave Box GMD Address	Rochester City	NY State	14642 Zip Code
E- Mail Address: _____			
SEND PROGRESS REPORT: <input type="checkbox"/> Secured Site Access (online) <input type="checkbox"/> e Mail (Secured attachment) <input type="checkbox"/> Fax (provider secured) <input type="checkbox"/> DO NOT SEND PROGRESS			
<i>If a selection is not indicated, no progress reports will be made available</i>			
Send feedback report to:			
<input type="checkbox"/> Same as above or			
_____ Name (First, Last)		_____ Phone (area code + number)	
_____ Facility		_____ Fax (area code + number)	
Pediatrics only: Tobacco Users' relationship to child: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other (specify) _____			
Child/Children's name: (to help with recordkeeping) _____			