Refer-to-Quit Referral Form

Patient stamp, label, OR info (name, record number, DOB, date):

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

Step-by-Step:

- If a tobacco user would like help from the Quitline, complete form.
- Fax completed form to 1-866-784-8329.
- A Quitline 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.
- The Quitline program is a free service for all New York State residents regardless of insurance status.

Code:
Special Programs Only

Tobacco Users: Complete This Section

(Please print)

_____ _____ Date of Birth
First Name Last Name _____ / _____ / _____

_____ _____ ___ _____
Mailing Address City State Zip Code

❑ Male ❑ Female **( ) _____ - _____** **( ) _____ - _____**
Gender Primary Phone (area code + number) Secondary Phone (Area code + number)

E-mail Address: _____

When should we call? ☐ Morning ☐ Afternoon ☐ Evening ☐ No preference May we leave a message? ☐ Yes ☐ No

Language Preference: ☐ English ☐ Spanish ☐ 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 below 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: Phone number

_____ **( ) _____ - _____**
Facility: Fax number

_____ _____ _____ _____
Address: City State Zip

E-mail address: _____

SEND PROGRESS REPORT VIA SECURED: ☐ Secured Site Access ☐ E-mail (Secured Attachment)
☐ Fax (Provider Secured) ☐ DO NOT SEND PROGRESS REPORT

If a selection is not indicated, no progress reports will be made available

Send feedback report to:
☐ Same as above or _____ **( ) _____ - _____**
Name Phone number

_____
Facility **( ) _____ - _____**
Fax number

E-mail address: _____

PEDIATRICS ONLY: Tobacco Users' relationship to child: ☐ Mother ☐ Father ☐ Other (specify) _____
Child/Children's name: (to help with recordkeeping) _____