GEORGIA TOBACCO QUIT LINE FAX REFERRAL FORM

Fax Number: 1-800-483-3114

FAX SENT DATE: ____________________

Provider Information:

CLINIC NAME: **CLINIC ZIP CODE**

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**

ADDRESS **CITY** ZIP CODE

PRIMARY PHONE NUMBER **H** W C **SECONDARY PHONE NUMBER** H W C

HM **W K C E L L**

WK

CELL

CELL **SECONDARY PHONE NUMBER** ☐ ☐ ☐ ☐ ☐ ☐

LANGUAGE PREFERENCE (*PLEASE CHECK ONE*) ENGLISH ☐ SPANISH ☐ OTHER ☐

By participating in this program I understand that outcome information may be shared with my provider for purposes of my treatment.

________ I am ready to quit tobacco and request the Georgia Tobacco Quit Line contact me to help me with my quit plan.
(Initial)

________ I **DO NOT** give my permission to the Georgia Tobacco Quit Line 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:** ____________________

The **Georgia Tobacco Quit Line** will call you. Please check the BEST 3-hour time frame for them to reach you. ***NOTE: The Quitline is open 7 days a week; call attempts over a weekend may be made at times other than during this 3-hour time frame.***

© 2016. All rights reserved. Reprinted with permission of copyright owner. All trademarks are the property of their respective owners.

Confidentiality Notice: This facsimile contains confidential information. If you have received this facsimile in error, please notify the sender immediately by telephone and confidentially dispose of the material. **Do not review, disclose, copy, or distribute.**

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

WITHIN THIS 3-HOUR TIME FRAME, PLEASE CONTACT ME AT (*CHECK ONE*): ☐ **Primary #** ☐ **Secondary #**