

FAX-TO-QUIT REFERRAL FORM

Date _____



Use this form to refer patients who are ready to quit tobacco in the next 30 days to the Colorado QuitLine.

PROVIDER(S): Complete this section

Provider name _____	Contact name _____
Clinic/Hosp/Dept _____	E-mail _____
Address _____	Phone () - _____
City/State/Zip _____	Fax () - _____

PLEASE INDICATE IF THE PATIENT HAS MEDICAID: YES NO

If yes, and you are prescribing tobacco cessation medication, please complete the Medicaid prior-authorization form on the back of this form and provide patient with a prescription. All FDA-approved tobacco cessation medications are available.

Does patient have any of the following conditions?

pregnant uncontrolled high blood pressure heart disease

YES, I authorize the QuitLine to send the patient over-the-counter nicotine replacement therapy.

Provider signature

A provider signature is required to authorize the QuitLine to dispense nicotine replacement therapy for patients with any of the above conditions.

Comments _____

PATIENT: Complete this section

Initial Yes, I am ready to quit and ask that a QuitLine coach call me. I understand that the Colorado QuitLine will inform my provider about my participation.

Best times to call? morning afternoon evening weekend

May we leave a message? Yes No

Are you hearing impaired and need assistance? Yes No

Insurance? Yes No

Insurance carrier: _____

Member ID: _____

Medicaid? Yes No

Date of birth: / / Gender M F

Patient name (Last) _____ (First) _____

Address _____ City _____ CO _____

Zip code _____ E-mail _____

Phone #1 () - _____ Phone #2 () - _____

Language English Spanish Other _____

Patient signature _____ **Date** _____

PLEASE FAX THIS PATIENT FAX REFERRAL FORM TO: 1-800-261-6259

Or mail to: Colorado QuitLine, National Jewish Health, 1400 Jackson St., M305, Denver, CO 80206

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