Indiana Tobacco Quitline FAX Referral Form
Fax Number: 1-800-483-3114

INDIANA TOBACCO QUITLINE
1-800-QUIT-NOW
WE'LL SHOW YOU HOW

Provider Information: **Fax Sent Date:** _____/_____/_____

Clinic Name: _____

Health Care Provider: _____

Contact Name: _____

I am a HIPAA-Covered Entity (Please check one) ___ Yes __ No __ I Don't Know

Fax: (_____) _____ - _____ **Phone** (_____) _____ - _____

Comments:

Patient Information: **Gender:**_____**male /** _____**female** **Pregnant?** ____Y ____N

Patient Name: _____ **DOB:** _____/_____/_____

Address: _____ **City:** _____ **Zip:**_____

Primary #: (_____) _____ - _____ **Type:** ____ **HM** ____ **WK** ____ **CELL** ___**OTHER**

Secondary #: (_____) _____ - _____ **Type:** ____ **HM** ____ **WK** ____ **CELL** ___**OTHER**

Language Preference (check one): _____ **English** _____ **Spanish** _____ **Other -** _____

Tobacco Type (check ALL that apply): ____ **Cigarettes** ____ **Smokeless Tobacco** _____ **Cigar** _____ **Pipe**

_____ I am ready to quit tobacco and request the Indiana Tobacco Quitline contact me to help me with my quit plan.
(Initial)

_____ I **DO NOT** give my permission to the Indiana Tobacco Quitline to leave a message when contacting me.
(Initial)

Patient Signature: _____ **Date:** _____/_____/_____

The Indiana Tobacco Quitline 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.

❑ **6am - 9am** ❑ **9am - 12pm** ❑ **12pm - 3pm** ❑ **3pm - 6pm** ❑ **6pm - 9pm**

Within this 3-hour time frame, please contact me at (check one): ____ **Primary** ____ **Secondary**
