FAX-TO-QUIT REFERRAL FORM

Date _____

COLORADO QuitLine™ Be tobacco free

Use this form to refer patients who are ready to quit tobacco or are thinking of quitting to the Colorado QuitLine.

PROVIDER(S): Complete this section

Provider name | Contact name

Clinic/Hosp/Dept | E-mail

Address | Phone ( ) –

City/State/Zip | Fax ( ) –

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 interested in quitting 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