COLORADO QUITLINE FAX FORM

Fax to: 1-800-261-6259

Use this form to refer individuals who are ready to quit tobacco or thinking about quitting to the Colorado QuitLine for free support.

COLORADO QuitLine™ Be tobacco free

PROVIDER INFORMATION (Print Clearly)

Patient progress reports will be faxed to HIPAA-covered entities ONLY. A valid fax number must be provided to receive reports.

** Indicates Required Fields*

Provider name* (First) _____ (Last) _____

Contact name (First) _____ (Last) _____

Clinic/Organization Name* _____ (be specific to support referral tracking)

Address _____

City _____ **State** _____ **Zip** _____

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

Type of HIPAA Covered Entity*:

☐ Healthcare Provider ☐ Health Plan ☐ Healthcare Clearinghouse ☐ Non-Covered Entity

QuitLine can provide nicotine replacement therapy (NRT) to enrolled clients aged 18 and older. Provider consent is required for the QuitLine to send NRT to patients with certain medical conditions. Do any of the following apply to this patient?

☐ Pregnant ☐ Breastfeeding ☐ Previously instructed to avoid nicotine replacement therapy

I authorize the QuitLine to send the patient nicotine replacement therapy.

Please sign here if the patient may use NRT. _____ **Date** _____
(Provider signature)

PATIENT INFORMATION (Print Clearly)

This section may be completed by the referring organization on behalf of the patient if the patient verbally consents to participation.

Patient name* (First) _____ (Last) _____

Address _____

City _____ **State** _____ **Zip*** _____

Phone* (_____) _____ - _____ **DOB** _____ / _____ / _____

☐ Home ☐ Cell ☐ Work **OK to leave a voice message at number provided?*** ☐ Yes ☐ No

The patient has consented to receive text messages† with motivational messages tailored to them and other program events, such as appointment reminders, medication shipment, and quit anniversaries?* ☐ Yes ☐ No

†Standard message and data rates may apply. The patient may opt-out at any time. Please verify patients under 18 are able to receive private messages on the number provided.

Do you require accommodation while participating in the program such as TTY, Translator or Relay Service? ☐ Yes ☐ No

If yes, please specify _____

☐ Medicare ☐ Medicaid ☐ Other Insurance Insurer Name: _____

**By submitting this form, I verify that the person being referred has consented to participate in the QuitLine program. ☐

**Participant or Authorized Representative verbal consent is required in order for the QuitLine to initiate contact with the patient.

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