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.

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. ☐

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

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

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(Provider signature)

INFORMACIÓN DEL PACIENTE (Escriba Claramente)

Esta sección deberá ser completada por la organización que hizo la referencia en nombre del paciente si es que el paciente expresa su consentimiento verbal para dicha participación.

Nombre del paciente* (Primer nombre) ____________ (Apellido) ____________

Dirección ____________

Ciudad ____________ **Estado** ________ **Código postal*** ________

Teléfono* (______) ______ - ______ **Fecha de nacimiento** ______ / ______ / ______

☐ Casa ☐ Celular ☐ Trabajo **¿Podemos dejar un mensaje de voz en el número provisto?*** ☐ Sí ☐ No **¿Idioma?** ☐ Inglés ☐ Español ☐ Otro ________

¿ El paciente ha dado su consentimiento para recibir mensajes de texto con mensajes motivacionales creados a su medida y otros eventos del programa, tales como recordatorios de sus citas, envíos, y aniversarios?* ☐ Sí ☐ No

Podrían aplicar cargos por mensajes estándar y uso de base de datos. El paciente puede optar salir del programa en cualquier momento. Favor de verificar que los pacientes menores de 18 años puedan recibir mensajes en el número provisto.

¿El paciente cuenta con seguro médico? [no es requerido para la participación] ☐ Sí ☐ No

Sí dijo Sí, por favor especifique ____________

¿Requiere arreglos especiales mientras participe del programa como TTY, Traductor o Servicio de relevo?

☐ Medicare ☐ Medicaid ☐ Otro Seguro médico Nombre del asegurador: ____________

***Al presentar esta forma, he verificado que la persona siendo referida ha dado su consentimiento** para participar del programa QuitLine.** ☐

**El consentimiento verbal del participante o del representante autorizado es requerido con el fin de que el programa de QuitLine pueda iniciar contacto con el paciente.

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