Montana Tobacco Quit Line Fax Referral Form

Fax to: 1-800-261-6259

Date ______________

PATIENT INFORMATION (PRINT CLEARLY)

Patient name (Last) _______________________ , (First) ____________________

Date of birth ______________

Gender ☐ M ☐ F

_____ *Initial* **I am ready to quit tobacco and request that the Montana Tobacco QuitLine contact me to help with my quit plans.**

I understand that the Montana Tobacco Quit Line will inform my provider about my participation and quitting results.

Patient signature ________________________________ **Date** ____________

This release shall be valid for one year after the above date.

Address ______________________ **City** ________________ **State** _____ **Zip code** __________

Phone #1 (_____) _______ - ________ **#2** (_____) _______ - ________ **E-mail** ____________________

Best times to call ☐ morning ☐ afternoon ☐ evening ☐ weekend **May we leave a message?** ☐ Yes ☐ No

Language ☐ English ☐ Spanish; Other ____________ **Are you hearing impaired and need assistance?** ☐ Yes ☐ No

PROVIDER INFORMATION (PRINT CLEARLY)

Provider name __________________________

Contact name __________________________

Clinic/Hosp/Dept __________________________

E-mail __________________________

Address __________________________

Phone (_______) _________ – __________

City/State/Zip __________________________

Fax (_______) _________ – __________

Provider consent is required to provide nicotine replacement therapy (NRT) to individuals who have certain medical conditions or are pregnant.

Please sign here if patient may use NRT. ________________________________

Provider signature

Comments ____

PLEASE COMPLETE FORM AND FAX OR MAIL TO

FAX 1-800-261-6259

Montana Tobacco Quit Line
National Jewish Health®
1400 Jackson St., S117A
Denver, CO 80206

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