Washington State Department of Health

DOH 340-221 October 2020

WASHINGTON STATE QUITLINE

FAX REFERRAL FORM

Fax To: 1-800-483-3078

Provider Information:

Date: ____/____/____

Health Care Provider Name: _____

Clinic Name: _____

Address: _____ City: _____ Zip: _____

Contact Name (nurse, med. asst., etc.): _____

Fax #: (_____) _____ - _____ Phone #: (_____) _____ - _____ Email: _____

I am a HIPAA-covered entity (check one): ❑ Yes ❑ No ❑ I don't know

Patient Information:

Sex: ❑ Male ❑ Female Pregnant ❑ Yes ❑ No

Patient Name: _____ DOB: ____/____/____

Address: _____ City: _____ Zip: _____

Home #: (_____) _____ - _____ Work #: (_____) _____ - _____ Cell #: (_____) _____ - _____

Insurance Plan: _____ Group #: _____ ID #: _____ Uninsured? ❑ Yes ❑ No

The Washington State Quitline will call you. The Quitline is open 7 days per week. Please check the best times for them to reach you:

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

Within this timeframe, please contact me at (check one): ❑ Home ❑ Work ❑ Cell

_____ *(Initial)* I am ready to quit tobacco and request that the Washington State Quitline contact me to help me with my quit plan.

_____ *(Initial)* I agree to have the Washington State Quitline tell my health care provider(s) that I enrolled in quitline services and provide them with the results of my participation.

_____ *(Initial)* I have an insurance plan and agree to check my benefit for free nicotine patches, gum, lozenges, or other medication to help me quit.

Congratulations on taking this important step! Telephone support from a Quit Coach will greatly increase your chance of success.

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