



1.800.QUIT.NOW

UTAH TOBACCO QUIT LINE
FAX REFERRAL FORM
Fax Number: 1-800-483-3076

FAX SENT DATE: ___/___/___

Provider Information:

CLINIC/HOSPITAL NAME

[Text input field]

CLINIC/HOSPITAL COUNTY

[Text input field]

HEALTH CARE PROFESSIONAL

[Text input field]

CLINIC/HOSPITAL CONTACT NAME

[Text input field]

CLINIC/HOSPITAL FAX NUMBER

[Text input field]

CLINIC/HOSPITAL PHONE NUMBER

[Text input field]

I AM A HIPAA COVERED ENTITY (PLEASE CHECK ONE)

YES

NO

DON'T KNOW

Patient Information:

PATIENT NAME

[Text input field]

DATE OF BIRTH

[Text input field]

GENDER

MALE

FEMALE

ADDRESS

[Text input field]

CITY

[Text input field]

ZIP CODE

[Text input field]

PRIMARY PHONE NUMBER

[Text input field]

HM

WK

CELL

SECONDARY PHONE NUMBER

[Text input field]

HM

WK

CELL

LANGUAGE PREFERENCE (PLEASE CHECK ONE)

ENGLISH

SPANISH

OTHER

[Text input field]

By participating in this program I understand that outcome information may be shared with my provider for purposes of my treatment.

I am ready to quit tobacco and request the Utah Tobacco Quit Line contact me to help me with my quit plan. (Initial)

I DO NOT give my permission to the Utah Tobacco Quit Line to leave a message when contacting me. (Initial) ** By not initialing, you are giving your permission for the quitline to leave a message.

PATIENT SIGNATURE: _____ DATE: ___/___/___

The Utah Tobacco Quit Line will call you. Please check the BEST 3-hour time frame for them to reach you. NOTE: The Quit Line is open 7 days a week; call attempts over a weekend may be made at times other than during this 3-hour time frame.

6AM - 9AM

9AM - 12PM

12PM - 3PM

3PM - 6PM

6PM - 9PM

WITHIN THIS 3-HOUR TIME FRAME, PLEASE CONTACT ME AT (CHECK ONE): Primary # Secondary #

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