LOUISIANA TOBACCO QUITLINE FAX REFERRAL FORM

Today's Date_____

FOR PROVIDER USE ONLY

1. Provider Name: _____ **2. Contact Name:** _____
3. Provider Address: _____
4. Provider – Phone: (_____) _____-_____ **5. Provider – FAX:** (_____) _____-_____
Comments:

ASK	ADVISE	ASSESS	ASSIST	ARRANGE
Date _____ Initial _____ # of cigarettes per day _____	Discussed: o Relevance o Risks o Rewards o Roadblocks	o No Interest o Quit Later o Ready o Quit < 6 mos o Maintain > 6 mos o Relapse	Set quit date _____ o Counsel o Quitline materials o Pharmacotherapy	o Referral to Quitline o Call o Referral to cessation group o Follow-up appt. given

Please give patient a PATIENT copy before faxing to the Quitline (877) 747-9528

FOR PATIENT USE ONLY

_____ Patient Initials

I give my permission to my health care provider to fax this information to the Louisiana Tobacco Quitline. I understand the Quitline will update my physician on my progress and a Quitline staff person will call me.

_____ Patient Initials

If I am not available, I give the Quitline permission to send a letter to my address and/or leave a detailed message on my voice mail or with the person who answers the phone.

Patient Name (Last, First): _____ **DOB:** ____/____/_____

Gender: __ **M** __ **F** **Pregnant?:** __**Y** __**N** **Health Insurance Name:** _____

Language Preference (check one): __ **English** __ **Spanish** __ **Other:** _____

Tobacco Type (check primary use): __ **Cigarettes** __ **Smokeless** __ **Tobacco** __ **Cigar** __ **Pipe**

Patient Address – Street: ____ _____

City/State: _____ **ZIP:** ___ _____

Patient Signature: _____ **Today's Date:** _____

The Quitline will call you. Please check the best times for the Quitline to reach you.
Preferred Phone: (_____) _____-_____ **Alternate Phone:** (_____) _____-_____
__ **8am-12pm** __**12pm-3pm** __**3pm-6pm** __**6pm-9pm** __**9pm-12pm** __**M** __**T** __**W** __**TH** __**F** __**S** __**S**
Comments:

FOR LOUISIANA QUITLINE ONLY

Specialist Initials: _____ **Contact Date:** ____/_____/_____ **or** __ **Did not reach after 3 attempts**

Services Provided: (✓ **all that apply)** __ **Self Help Materials** __ **Pharmacotherapy Referral** __ **Cessation Referral**

Stage of Readiness: _____ **Planned Quit Date:** _____
Comments:

THE LOUISIANA CAMPAIGN FOR TOBACCO-FREE LIVING

American Cancer Society®

Louisiana Tobacco Control Program