

FAX REFERRAL FORM



Fax Number: 1-800-483-3114

Date Sent: ____/____/____

Provider Information:

CLINIC NAME

CLINIC ZIP CODE

HEALTH CARE PROVIDER

CONTACT NAME

FAX NUMBER

PHONE NUMBER

I AM A HIPAA COVERED ENTITY (PLEASE CHECK ONE)

YES

NO

DON'T KNOW

Patient Information:

PATIENT NAME

DATE OF BIRTH

GENDER

MALE FEMALE

ADDRESS

CITY

ZIP CODE

PRIMARY PHONE NUMBER

HOME WORK CELL

SECONDARY PHONE NUMBER

HOME WORK CELL

LANGUAGE PREFERENCE (PLEASE CHECK ONE)

ENGLISH

SPANISH

OTHER

CHECK IF PATIENT IS CURRENTLY PREGNANT

IF APPLICABLE, PATIENT MEDICAID ID # (11 digits):

____ I am ready to quit tobacco and request the Nebraska Tobacco Quitline contact me to help me with my quit plan.

INITIAL

____ I give my permission to the Nebraska Tobacco Quitline to leave a message when contacting me at the number(s) provided above.

INITIAL

____ I give my permission to the Nebraska Tobacco Quitline to share information with my provider for the purposes of my health care treatment.

INITIAL

The Nebraska Tobacco Quitline will call you. Please check the BEST 3-hour time frame for them to reach you. **NOTE: The Quitline 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 (PLEASE CHECK ONE):

PRIMARY # SECONDARY #

PATIENT SIGNATURE: _____

DATE: ____/____/____

If a prescription has been written for a Medicaid patient, please check the product:

Nicotine Gum: _____

Nicotine Patch: _____

Nicotine Lozenge: _____

Varenicline: (Chantix) _____

Bupropion: (Zyban) _____

Nicotine Nasal Spray: _____

Nicotine Inhaler: _____

Confidentiality Notice: This facsimile contains confidential information.

If you have received this facsimile in error, please notify the sender immediately by telephone and confidentially dispose of the material. **Do not review, disclose, copy, or distribute.**