

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

HM

WK

CELL

SECONDARY PHONE NUMBER

HM

WK

CELL

LANGUAGE PREFERENCE (PLEASE CHECK ONE)

ENGLISH

SPANISH

OTHER

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 permission for the Nebraska Tobacco Quitline to leave a message when contacting me.

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 (CHECK ONE):

PRIMARY #

SECONDARY #

If prescription has been written, please check the products:

Nicotine Gum: _____

Nicotine Patch: _____

Nicotine Lozenge: _____

Varenicline: (Chantix) _____

Bupropion: (Zyban) _____

Nicotine Nasal Spray: _____

Nicotine Inhaler: _____

PATIENT SIGNATURE: _____

DATE: ____/____/____

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.**