FAX REFERRAL FORM

NEBRASKA TOBACCO QUITLINE

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

PHONE NUMBER

HOME WORK CELL

LANGUAGE PREFERENCE *(PLEASE CHECK ONE)* ☐ ENGLISH ☐ SPANISH ☐ OTHER

☐ CHECK IF PATIENT IS CURRENTLY PREGNANT

For Heritage Health (Medicaid) patients only:

PLEASE SELECT HEALTH PLAN:

☐ MAGELLAN ☐ NEBRASKA TOTAL CARE ☐ UNITED HEALTH CARE ☐ WELLCARE

PATIENT MEDICAID ID # *(11 digits):*

_____ INITIAL 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.

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

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: _____

PATIENT SIGNATURE: _____ **DATE:** _____ / _____ / _____