

# Oregon Tobacco Quit Line Fax Referral Form

Fax Number: 1-800-483-3114

**Provider Information:**

Fax Sent Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Clinic Name: \_\_\_\_\_

Health Care Provider: \_\_\_\_\_

Contact Name: \_\_\_\_\_

I am a HIPAA-Covered Entity (Please check one)     Yes     No     I Don't Know

Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Comments:

**Patient Information:**

Gender: \_\_\_\_ male / \_\_\_\_ female    Pregnant? \_\_\_\_ Y \_\_\_\_ N

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Type: \_\_\_\_ HM \_\_\_\_ WK \_\_\_\_ CELL \_\_\_\_ OTHER

Secondary #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Type: \_\_\_\_ HM \_\_\_\_ WK \_\_\_\_ CELL \_\_\_\_ OTHER

Language Preference (check one): \_\_\_\_ English \_\_\_\_ Spanish \_\_\_\_ Other - \_\_\_\_\_

Tobacco Type (check ALL that apply): \_\_\_\_ Cigarettes \_\_\_\_ Smokeless Tobacco \_\_\_\_ Cigar \_\_\_\_ Pipe

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

\_\_\_\_ I **DO NOT** give my permission to the Oregon Tobacco Quit Line to leave a message when contacting me.  
(Initial)

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

The Oregon 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.

5am - 9am

9am - 12pm

12pm - 3pm

3pm - 6pm

6pm - 9pm

**Pacific Time**

Within this 3-hour time frame, please contact me at (check one): \_\_\_\_ Primary \_\_\_\_ Secondary phone.

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