Oregon Health Authority

Oregon Tobacco Quit Line Fax Referral Form
Fax Number: 1-800-483-3114

Provider Information:

FAX SENT DATE: _____/_____/_____

NAME OF CLINIC, PRACTICE, PHARMACY OR HOSPITAL

CLINIC ZIP CODE

REQUIRED: I AM A HIPAA COVERED ENTITY (PLEASE CHECK ONE) YES ☐ NO ☐ DON'T KNOW ☐

NAME OF REFERRING PROVIDER e.g. CLINICIAN, HEALTH CARE PROFESSIONAL

CONTACT NAME

FAX NUMBER

PHONE NUMBER

Patient Information:

PATIENT NAME

DATE OF BIRTH

GENDER IDENTITY

ADDRESS

CITY

ZIP CODE

PRIMARY PHONE NUMBER **HM** ☐ **WK** ☐ **CELL** ☐

SECONDARY PHONE NUMBER **HM** ☐ **WK** ☐ **CELL** ☐

LANGUAGE PREFERENCE

NOTES: CURRENT CESSATION MEDICATIONS

By participating in this program I understand that outcome information may be shared with my provider for purposes of my treatment.

_____ 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) ***** By not initialing, you are giving your permission for the quitline to leave a message.***

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 time frame.***

☐ **8AM – 9AM** ☐ **9AM – 12PM** ☐ **12PM – 3PM** ☐ **3PM – 6PM** ☐ **6PM – 9PM**

WITHIN THIS TIME FRAME, PLEASE CONTACT ME AT (*CHECK ONE*): ☐ **Primary #** ☐ **Secondary #**