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)** YESNODON’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.

*Verbal consent*

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

*Verbal consent* *\*\* By not initialing, you are giving your permission for the Quit Line to leave a message.*

**PATIENT SIGNATURE: Consent obtained by:** **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 #**