

Please circle one:

- County Health Department
- Community Health Center
- Area Health Education Center
- Other



County _____

Florida Quitline Referral Form

Complete all of the following:

Provider Information:

- Advised no tobacco in pregnancy and postpartum
- Assessed that patient wants to quit in the next 30 days
- Obtained permission to refer to a cessation toll-free number 1-87-QUIT-NOW-6

The Quitline is an entity that is compliant with the Health Insurance Portability and Accountability Act (HIPAA). The Quitline will only be able to share service outcome information with you if you verify that your organization is a HIPAA-covered entity and that the use of information is for treatment purposes as permitted by HIPAA.

Please indicate whether you are a HIPAA covered entity: **I am a HIPAA Covered Entity** ___ Yes ___ No

Practice Name _____

Referring Provider _____

Practice address _____ Zip Code _____

Telephone _____ Fax _____

Participant Information: Gender: ___ male ___ female Pregnant? ___ Y ___ N

Participant Name: _____ DOB: ____/____/____

Address: _____ City: _____ Zip: _____

Primary #: (____) _____ - _____ Type: ___ HM ___ WK ___ CELL ___ OTHER

Language Preference (check one): ___ English ___ Spanish ___ Other - _____

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

My signature gives permission for my provider to FAX this form to the Florida Quitline. I understand that a Quitline specialist will call me within the next week.

Patient Signature _____ Date: _____

FAX THIS FORM TO 1-800-483-3114.

Questions? Call the Florida Quitline, 1-(877) U CAN NOW