

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.