



Patient Referral/Consent Form

Patient Information

Patient's Name: _____ **Date:** _____

Telephone #: _____ **Best Contact Time:** _____ **Daytime** _____ **Evening** _____

Patient/Client Signature for Consent: _____

I hereby authorize my healthcare provider to release my contact information and information regarding my tobacco use to the Alabama Tobacco Quitline. This authorization is continuing. I understand that the Alabama Tobacco Quitline will contact me to provide information, offer support in quitting tobacco and will provide progress reports to my healthcare provider. My participation is voluntary. I understand that any information I provide will be kept confidential.

Comments: _____

Healthcare Provider

The Alabama Tobacco Quitline offers a 4 week supply of nicotine patches to Alabama residents who qualify at no charge.

Please verify if the above patient is medically appropriate to use the nicotine patch. Yes No

I request that the Alabama Tobacco Quitline, operated by IQH, contact my patient/client minor child for the provision of tobacco cessation services.

Signature: _____ **Date:** _____

Please mark the appropriate box:

- | | | |
|--|--|---|
| <input type="checkbox"/> Primary Physician | <input type="checkbox"/> Social Worker | <input type="checkbox"/> Patient Refuses Services |
| <input type="checkbox"/> Counselor | <input type="checkbox"/> Healthcare Provider | <input type="checkbox"/> Quitline Number Given |
| <input type="checkbox"/> Parent/Legal Guardian | <input type="checkbox"/> Case Manager | Tentative Discharge Date:
_____ |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Other | |

Print Name: _____

Address: _____

Telephone #: (_____) _____

Send to: IQH, Alabama Tobacco Quitline
385 B Highland Colony Parkway, Suite 503
Ridgeland, Mississippi 39157

Telephone #: 1-800-QUIT-NOW
1-800-784-8669
Fax #: 1-601-899-8650