PA FREE Quitline
PATIENT FAX REFERRAL FORM
Fax to: 1-800-261-6259

pennsylvania
DEPARTMENT OF HEALTH

Today's Date _____

Fax referral to the PA FREE Quitline is for patients who are ***ready to quit in the next 30 days AND ready to accept a call from the Quitline.*** *If neither of these conditions is met, provide patient with Quitline or other tobacco cessation resource information.*

PROVIDER(S): Complete this section. (Please print clearly.)

Provider Name fill in NAME of person making referral Contact Name : designated contact person

Clinic/Hosp/Dept E-mail

Address Phone

City/State/Zip Fax

Please Check ☐ Patient agrees with provider to be referred to the PA FREE Quitline.

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

☐ In the absence of the patient being physically present to provide signature, provider please check to indicate that **patient provided verbal consent** to be referred to the PA FREE Quiltine.

PATIENT: Complete this section. (Please print clearly.)

_____ *Initial* Yes, I am ready to quit and ask that a Quitline coach call me. I understand that the PA FREE Quitline will inform my provider about my participation. I also give permission to the PA FREE Quitline to share my information with the Pennsylvania Department of Health. This information will be kept private and confidential by the Pennsylvania Department of Health.

Best times to call? (Please check all that apply.) ☐ Morning (8-12) ☐ Afternoon (12-5) ☐ Evening (5-9) ☐ Anytime

[Caller ID will display 1-800-784-8669 (Quit-Now).] ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Weekend ☐ Any day

May we leave a message? ☐ Yes ☐ No

Are you hearing impaired and need assistance? ☐ Yes ☐ No

Date of Birth / / Gender ☐ M ☐ F

Patient Name (Last) (First)

Address City State

Zip Code E-mail

Phone #1 ( ) - Phone #2 ( ) -

Language ☐ English ☐ Spanish ☐ Other _____

Patient Signature Date

PROVIDER PLEASE FAX COMPLETED FORM TO: 1-800-261-6259

Or mail to: PA FREE Quitline, c/o National Jewish Health®, 1400 Jackson St., S117A, Denver, CO 80206

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