

MONTANA TOBACCO



Montana Tobacco Quit Line
Fax Referral Form

Fax to: 1-800-261-6259

Date _____

PATIENT INFORMATION (PRINT CLEARLY)

Patient name (Last) _____, (First) _____

Date of birth _____

Gender M F

Initial I am ready to quit tobacco and request that the Montana Tobacco QuitLine contact me to help with my quit plans.

I understand that the Montana Tobacco Quit Line will inform my provider about my participation and quitting results.

Patient signature _____ Date _____

This release shall be valid for one year after the above date.

Address _____ City _____ State _____ Zip code _____

Phone #1 (____) _____ - _____ #2 (____) _____ - _____ E-mail _____

Best times to call morning afternoon evening weekend May we leave a message? Yes No

Language English Spanish; Other _____ Are you hearing impaired and need assistance? Yes No

PROVIDER INFORMATION (PRINT CLEARLY)

Provider name _____

Contact name _____

Clinic/Hosp/Dept _____

E-mail _____

Address _____

Phone (____) _____ - _____

City/State/Zip _____

Fax (____) _____ - _____

Provider consent is required to provide nicotine replacement therapy (NRT) to individuals who have certain medical conditions or are pregnant.

Please sign here if patient may use NRT. _____

Provider signature

Comments _____

PLEASE COMPLETE FORM AND FAX OR MAIL TO

FAX 1-800-261-6259

Montana Tobacco Quit Line
National Jewish Health™
1400 Jackson St., M302
Denver, CO 80206

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