



WASHINGTON STATE TOBACCO QUIT LINE
FAX REFERRAL FORM Fax Number: 1-800-483-3078

Provider Information:

Date: ___/___/___

Health Care Provider Name: _____

Clinic Name: _____

Clinic Address: _____ City: _____ Zip: _____

Contact Name (nurse, med. asst., etc.): _____

Fax: (____) ____ - _____ Phone (____) ____ - _____ Email: _____

Patient Information:

Gender: Male ___ Female ___

Pregnant? Y ___ N ___

Patient Name: _____ DOB: ___/___/___

Address: _____ City: _____ Zip: _____

Home #: (____) ____ - _____ Wk #: (____) ____ - _____ Cell #: (____) ____ - _____

The Washington Tobacco Quit Line will call you. Please check the best times for them to reach you. The Quit Line is open 7 days a week:

- 6am - 9am 9am - 12pm 12pm - 3pm 3pm - 6pm 6pm - 9pm

Within this 3-hour time frame, please contact me at (check one): ___hm/___wk/___cell

I am ready to quit tobacco and request the Washington Tobacco Quit Line contact me to help (Initial) me with my quit plans.

I agree to have the Washington Tobacco Quit Line tell my health care provider(s) that I (Initial) enrolled in Quit Line services and provide them with the results of my participation.

Interpretation performed (Initial)

Congratulations on taking this important step! Telephone support from a Quit Coach will greatly increase your chance of success.

Patient Signature: _____ Date: ___/___/___

Confidentiality Notice: This facsimile contains confidential information. If you have received this facsimile in error, please notify the sender immediately by telephone and confidentially dispose of the material. Do not review, disclose, copy, or distribute.