



1-800-QUIT-NOW

QuitlineNC FAX REFERRAL FORM

Fax completed form to: **1-800-483-3114**

Referring Organization Information:

Date Fax Sent: __/__/__

Organization Name: _____ County _____
(Hospital - Clinic)

In order to receive a Participant's Outcome Report, you must be a HIPAA-Covered Entity

- I am a HIPAA-Covered Entity? (Please check one) Yes No I Don't Know
- Check if you do NOT want to receive an Outcomes Report.

Fax: (____) ____ - ____ Person Referring: _____ Contact Phone: (____) ____ - ____

Person Being Referred to Quitline:

Name: _____ DOB: __/__/__

Address: _____ City: _____ Zip: _____

Gender: Male Female Pregnant?: Yes No

Best # to call: (____) ____ - _____ Type: ___ Home ___ Work ___ CELL

Back-up # to call: (____) ____ - _____ Type: ___ Home ___ Work ___ CELL

Language Preference (check one): English Spanish Other - _____

____ (Initial) I am ready to quit tobacco use within the next 30 days, or have recently quit. I request QuitlineNC to contact me to help me with my quit plan.

____ (Initial) I **DO NOT** give permission to QuitlineNC to leave a message when contacting me.

Signature: _____ Date: __/__/__

Check the BEST time for QuitlineNC to call:

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

NOTE: The QuitlineNC is open 7 days a week; but call attempts to participants are only made until midnight. Calls made over the weekend may be made at times outside of the 3-hour time frame selection.

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.**

DOUBLE YOUR CHANCES OF QUITTING FOR GOOD

