

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



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	Contact Name
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 Quitline.

**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

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