NEW JERSEY QUITLINE
1-866-NJ-STOPS

New Jersey Quitline

FAX REFERRAL FORM
Fax Number: (800) 483-3114

**FAX SENT DATE:** _______/_______/_______

# Provider Information:

**CLINIC NAME**

**CLINIC ZIP CODE**

**HEALTH CARE PROVIDER**

**CONTACT NAME**

**FAX NUMBER**

**PHONE NUMBER**

**I AM A HIPAA COVERED ENTITY (PLEASE CHECK ONE)**

YES ☐ NO ☐ DON'T KNOW ☐

# Patient Information:

**PATIENT NAME**

**DATE OF BIRTH**

**GENDER**

☐ MALE ☐ FEMALE

**ADDRESS**

**CITY**

**ZIP CODE**

**PRIMARY PHONE NUMBER** HM ☐ WK ☐ CELL ☐

**SECONDARY PHONE NUMBER** HM ☐ WK ☐ CELL ☐

**LANGUAGE PREFERENCE** (*PLEASE CHECK ONE*)

ENGLISH ☐ SPANISH ☐ OTHER

By participating in this program I understand that outcome information may be shared with my provider for purposes of my treatment.

_____ I am ready to quit tobacco and request the New Jersey Quitline contact me to help me with my quit plan.

________*Verbal Consent*

_____ I **DO NOT** give my permission to the New Jersey Quitline to leave a message when contacting me.

________*Verbal Consent* ***** By not initialing, you are giving your permission for the quitline to leave a message.***

**PATIENT SIGNATURE:**_______________________________________________ **DATE:** _____/_____/______

Verbal Consent obtained by:

The New Jersey Quitline will call you. Please check the BEST 3-hour time frame for them to reach you. ***NOTE: The Quitline is open 7 days a week; call attempts over a weekend may be made at times other than during this 3-hour time frame.***

☐ **6AM – 9AM** ☐ **9AM – 12PM** ☐ **12PM – 3PM** ☐ **3PM – 6PM** ☐ **6PM – 9PM**

**WITHIN THIS 3-HOUR TIME FRAME, PLEASE CONTACT ME AT** (*CHECK ONE*): ☐ **Primary #** ☐ **Secondary #**

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