



MARYLAND TOBACCO QUITLINE FAX REFERRAL FORM

Fax Number: 1-800-483-3114

FAX SENT DATE: ____/____/____

Provider Information:

CLINIC NAME TO APPEAR IN QUITLINE REPORTS

CLINIC ZIP CODE

NAME OF PROVIDER MAKING REFERRAL

CONTACT NAME

FAX NUMBER

PHONE NUMBER

I AM A HIPAA COVERED ENTITY (PLEASE CHECK ONE)
(only HIPAA-covered entities receive feedback from the
Quitline for clients they refer)

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

____ I am ready to quit tobacco and request the Maryland Tobacco Quitline contact me to help me with my quit plan.
(Initial)

____ I **DO NOT** give my permission to the Maryland Tobacco Quitline to leave a message when contacting me.
(Initial) **** By not initialing, you are giving your permission for the quitline to leave a message.**

PATIENT SIGNATURE: _____ DATE: ____/____/____

The Maryland Tobacco 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 #