Georgia Department of Public Health

GEORGIA TOBACCO QUIT LINE FAX REFERRAL FORM

Fax Number: 1-800-483-3114

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 H ☐ W ☐ C ☐ | **SECONDARY PHONE NUMBER** H ☐ W ☐ C ☐

LANGUAGE PREFERENCE (*PLEASE CHECK ONE*) ENGLISH ☐ SPANISH ☐ OTHER ☐

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

_____ I **DO NOT** give my permission to the Georgia Tobacco Quit Line 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 **Georgia Tobacco Quit Line** 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 #**