

Please circle one:

County Health Department

Community Health Center

Area Health Education Center

County \_\_\_\_\_

## Florida Quit for Life Line Referral Form



PROVIDER

### Complete all of the following:

- Advised no tobacco in pregnancy and postpartum
- Assessed that patient wants to quit in the next 30 days
- Obtained permission to refer to the Quitline
- Obtained permission to be contacted about participating in a free local smoking cessation class Y\_\_ N\_\_  
If yes, which language would you prefer? English\_\_\_\_\_ Spanish\_\_\_\_\_ Creole\_\_\_\_\_

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Referring Provider \_\_\_\_\_

Practice Name \_\_\_\_\_

Practice address \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

PATIENT

Assistance from the Quit for Life Line will increase your chances for success in quitting tobacco.

The QuitLine provides:

- Friendly, respectful support
- No-pressure, helpful counseling
- Expertise in tobacco and nicotine
- Ways to boost your confidence

### Best day and time for Quitline staff to call me:

Day \_\_\_\_\_ Time \_\_\_\_\_

*My signature gives permission for my provider to FAX this form to the Florida Quit for Life Line. I understand that a Quitline specialist will call me within the next week.*

Patient Signature \_\_\_\_\_

Patient telephone \_\_\_\_\_ Zip Code \_\_\_\_\_

FAX THIS FORM TO (877)747-9528

Questions? Call the Florida Quit for Life Line, 1-(877) U CAN NOW