



Mississippi Tobacco Quitline Fax Referral/Consent Form

Health Care Provider Information – Please Print

Health Care Provider (First Last, Title):				
Organization/Clinic Full Name:				
Organization:	<input type="checkbox"/> Health Department	<input type="checkbox"/> Hospital	<input type="checkbox"/> Clinic	<input type="checkbox"/> Other
Type of Practice:	<input type="checkbox"/> OB-GYN	<input type="checkbox"/> Family Practice	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Other
Fax Number: () -	Attention:			
Phone: () -	Email:			
Have you discussed this tobacco cessation program with this patient?			<input type="checkbox"/> YES	<input type="checkbox"/> NO
May IQH provide nicotine replacement therapy products to this patient?			<input type="checkbox"/> YES	<input type="checkbox"/> NO

Patient Information – Please Print

First Name:	Last Name:	Middle Initial:
Mailing address:	City:	State/Zip:
Phone: () -	E-mail:	
May we leave a message: <input type="checkbox"/> YES <input type="checkbox"/> NO	Language Preference: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other :	
The Mississippi Tobacco Quitline Staff can call me during the following times (check all that apply):		
<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening		
I give my consent for the Mississippi Tobacco Quitline to call me and provide follow-up to my healthcare provider:		
_____		(patient's signature)

Complete and **Fax** this form to: **(601) 899-8650/1-800-692-9023** or **referrals@iqhquitline.com**

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