Mississippi tobaccoQUITLINE 1.800.QUITNOW
1.800.784.8669

Mississippi Tobacco Quitline Fax Referral/Consent Form

Health Care Provider Information – Please Print

Health Care Provider (First Last, Title):

Organization/Clinic Full Name:

Organization: ☐ Health Department ☐ Hospital ☐ Clinic ☐ Other

Type of Practice: ☐ OB-GYN ☐ Family Practice ☐ Pediatrics ☐ Other

Fax Number: ( ) -	**Attention:**
Phone: ( ) -	**Email:**

Have you discussed this tobacco cessation program with this patient? ☐ YES ☐ NO

May IQH provide nicotine replacement therapy products to this patient? ☐ YES ☐ NO

Patient Information – Please Print

First Name:	**Last Name:**	**Middle Initial:**
Mailing address:	**City:**	**State/Zip:**
Phone: ( ) -	**E-mail:**	
May we leave a message: ☐ YES ☐ NO	**Language Preference:** ☐ English ☐ Spanish ☐ Other :	

The Mississippi Tobacco Quitline Staff can call me during the following times (check all that apply):

☐ **Morning** ☐ **Afternoon** ☐ **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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