



CONNECTICUT
QUITLINE
1-800-QUIT-NOW

CONNECTICUT QUITLINE 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

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 Connecticut Quitline contact me to help me with my quit plan.
(Initial)

____ I **DO NOT** give my permission to the Connecticut 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 Connecticut 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 #

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