



**LOUISIANA TOBACCO QUITLINE FAX-TO-QUIT LOUISIANA REFERRAL FORM**  
***For Healthcare Providers***

QuitWithUsLa.Org 1-800-QuitNow (1-800-784-8669) Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**FAX #: 1-800-483-3114**

**HEALTHCARE PROVIDER INFORMATION**

<p>Remember the 5 A's in Intervention:</p> <p>Ask Advise Assess Assist Arrange</p>	<p>Clinic/Employer Name: _____</p> <p>Health Care Provider Name: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>Phone: (____) _____ - _____ Fax: (____) _____ - _____</p> <p>Please indicate if you are a HIPAA covered entity: <b>I am a HIPAA covered entity <input type="checkbox"/> YES <input type="checkbox"/> NO</b></p>
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**PATIENT INFORMATION**

<p>Patient Name: _____</p> <p>Address: _____</p> <p>City/State: _____ Zip: _____</p> <p>Preferred Contact Number: (____) _____ - _____</p> <p>Alternate Phone Number: (____) _____ - _____</p> <p>Health Insurance: _____</p>	<p>DOB: ____/____/____</p> <p>Gender: ____M ____F</p> <p>Pregnant: ____Y ____N</p> <p><b>Language Preference</b> ____English ____Spanish ____other</p> <p><b>Tobacco Type</b> ____Cigarettes ____Cigar ____Smokeless Tobacco ____Pipe</p>
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\_\_\_\_ Yes, I give my permission to my provider to fax this information to the Louisiana Tobacco Quitline on my behalf. I understand the Quitline will update my provider on my progress and a Quitline staff person will call me at the designated time below.

\_\_\_\_ If I am not available, I give the Quitline permission to send a letter to my address and/or leave a detailed message on my voicemail or with the person who answers the phone.

**The Quitline will call you at the number you have provided.**

**What is the best time of day for the Quitline to reach you?**

7am to 9am  9am to 12pm  12pm to 3pm  3pm to 6pm  6pm to 9pm

**\*\*\*\*For In-Patient Use Only. To Be Completed By Hospital Staff\*\*\*\***  
Contact this patient after \_\_\_\_\_ date.

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
**Date**

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Produced by The Louisiana Department of Health and Hospitals' Tobacco Control Program and The Louisiana Campaign for Tobacco-Free Living

**PLEASE GIVE PATIENT A COPY BEFORE FAXING TO THE QUITLINE AT 1-800-483-3114**



**Your Clinic recently referred a patient via the Louisiana Quitline Fax Referral Program.  
This form describes the type of service the patient received through the Louisiana Tobacco Quitline.  
Please place this in the patient's files.**

**Clinic Information**

Clinic Name:

Clinic Phone Number:

Clinic Fax Number:

**Patient Information**

Participants Name:

Participants Address:

Participants Primary Phone Number:

Participants Date of Birth:

**Outcomes**

Disposition:

Contact Date if Contacted:

Planned Quit Date (If accepted services):

Stage (If accepted services):

**NOTE:**

**Status**

**Accepted Services:** Participant was reached and accepted service.

**Declined Services:** Participant was reached and declined service.

**Unreachable:** Attempts were made to contact the participant during their best time, but the quitline was unable to reach the participant.

**Disposition**

**General Questions:** Participant asked general questions and the quitline and its services, but did not opt for an intervention or materials.

**Materials Only:** Participant requested quit guides only.

**One-Call:** Participant received a single call intervention with a Quit Coach.

**Multi Call:** Participant received an intervention with a Quit Coach and accepted additional proactive calls from the quitline.

**Nicotine Patch** – Participant met screening criteria for nicotine patch.

**Nicotine Gum** – Participant met screening criteria for nicotine gum.

**Nicotine Lozenge** – Participant met screening criteria for nicotine lozenge.

**\*\*CONFIDENTIALITY STATEMENT\*\***

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