NEW JERSEY QUITLINE
1-866-NJ-STOPS

New Jersey Quitline
FAX REFERRAL FORM
Fax Number: (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

By participating in this program I understand that outcome information may be shared with my provider for purposes of my treatment.

_____ I am ready to quit tobacco and request the New Jersey Quitline contact me to help me with my quit plan.

_____***Verbal Consent***

_____ I **DO NOT** give my permission to the New Jersey Quitline to leave a message when contacting me.

_____***Verbal Consent ** By not initialing, you are giving your permission for the quitline to leave a message.***

PATIENT SIGNATURE:_____ **DATE:** _____/_____/_____

Verbal Consent obtained by:

The New Jersey 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 #**