Fax Number: 1-800-483-3114

Patient File Number: _____

Provider Information:

Fax Sent Date: _____/_____/_____

Clinic Name: _____

Hospital Name: _____
(if applicable)

Health Care Provider: _____

Contact Name: _____

I am a HIPAA-Covered Entity (Please check one) ☐ **Yes** ☐ **No** ☐ **I Don't Know**

Fax: (_____) _____ - _____ **Phone** (_____) _____ - _____

Comments:

Patient Information: **Gender:_____male / _____female** **Pregnant? _____Y _____N**

Patient Name: _____ DOB: _____/_____/_____

Address: _____ City: _____ Zip:_____

Hm #: (_____) _____ - _____ **Wk #:** (_____) _____-_____ **Cell #:** (_____) _____ - _____

Language Preference (check one): ☐ **English** ☐ **Spanish** ☐ **Other - _____**

Tobacco Type (check primary use): ☐ **Cigarettes** ☐ **Smokeless Tobacco** ☐ **Cigar** ☐ **Pipe**

_____ I am ready to quit tobacco and request the North Carolina Tobacco Use Quitline contact me to help
(Initial) me with my quit plan.

_____ I **DO NOT** give my permission to the North Carolina Tobacco Use Quitline to leave a message
(Initial) when contacting me.

Patient Signature: _____ Date: _____/_____/_____

The North Carolina Tobacco Use 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.

☐ **8am - 12am EST** ☐ **12am - 3pm EST** ☐ **6pm - 9pm EST** ☐ **9pm - 12pm EST**

Within this 3-hour time frame, please contact me at (check one):☐hm/☐wk/☐cell

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