# Oregon Tobacco Quit Line Fax Referral Form

**Fax Number: 1-800-483-3114**

**Provider Information:** **Fax Sent Date: _____/_____/_____**

**Clinic Name:** _____

**Health Care Provider:** _____

**Contact Name:** _____

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

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

**Comments:**

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**Patient Information:** **Gender:_____male / _____female Pregnant? ____Y ____N**

**Patient Name:** _____ **DOB:** _____/_____/_____

**Address:** _____ **City:** _____ **Zip:**_____

**Primary #:** (_____) _____ - _____ **Type: ____ HM ____ WK ____ CELL ___OTHER**

**Secondary #:** (_____) _____ - _____ **Type: ____ HM ____ WK ____ CELL ___OTHER**

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

**Tobacco Type (check ALL that apply): ____ Cigarettes ____ Smokeless Tobacco _____ Cigar _____ Pipe**

_____ I am ready to quit tobacco and request the Oregon Tobacco Quit Line contact me to help me with my quit plan.
**(Initial)**

_____ I **DO NOT** give my permission to the Oregon Tobacco Quit Line to leave a message when contacting me.
**(Initial)**

**Patient Signature:** _____ **Date:** _____/_____/_____

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**The Oregon Tobacco Quit Line will call you. Please check the BEST 3-hour time frame for them to reach you. NOTE: The Quit Line is open 7 days a week; call attempts over a weekend may be made at times other than during this 3-hour time frame.**

**❑ 5am - 9am ❑ 9am - 12pm ❑ 12pm - 3pm ❑ 3pm - 6pm ❑ 6pm - 9pm**
**Pacific Time**

**Within this 3-hour time frame, please contact me at (check one): ____ Primary ____ Secondary phone.**