

Mississippi
tobaccoQUITLINE
1.800.QUITNOW
 WWW.QUITLINEMS.COM 1.800.784.8669

Referral/Consent Form

Referral's Name: _____ **Date:** _____

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

Primary Telephone: _____ **Back Up Telephone:** _____

Best Contact Time: _____ **Morning** _____ **Afternoon** _____ **Evening** _____ **Anytime**

I understand that the MS Tobacco Quitline will contact me to provide tobacco cessation information and offer counseling. My participation is voluntary. I understand that any information that I provide will be kept confidential. I give permission for my information to be exchanged between the MS Tobacco Quitline and my healthcare provider.

Patient/Client's Signature for Consent: _____

Some medical conditions may be a contraindication to the use of NRT products. If the referral is known to have any of the conditions listed below, please mark for our information.

Concerns:

- Heart disease
- High blood pressure
- Pregnancy
- RX for Chantix, Wellbutrin / Zyban
- Recent heart attack (within last 2 months)
- Diabetes
- Rx for depression

NRT patch concerns: Allergy to Adhesive tape Skin disorders, sensitivity

NRT gum concerns: Sodium restricted diet Stomach ulcers

Please check the type of treatment you recommend for the above referral:

- Cessation counseling Including NRT Cessation counseling using Rx meds (as prescribed) Cessation counseling ONLY, no meds or NRT

I request that the Tobacco Quitline, operated by IQH, contact my referral for the provision of tobacco cessation services. My signature verifies the referral be enrolled in the type of treatment designated above.

Signature: _____ Date: _____

Printed Name: _____ Clinic Name: _____

Office Address: _____

Telephone # () _____ Fax # () _____ Email: _____

Fax to: 1-601-899-8650
Mail to: IQH, Tobacco Quitline
 385B Highland Colony Parkway
 Suite 504
 Ridgeland, MS 31957

Email form to: referrals@iqhquitline.com
Web Address for registration and referral: www.quitlinems.com