

Please circle one:

County Health Department

Community Health Center

Area Health Education Center

County _____

Florida Quit for Life Line Referral Form



PROVIDER

Complete all of the following:

- Advised no tobacco in pregnancy and postpartum
- Assessed that patient wants to quit in the next 30 days
- Obtained permission to refer to the Quitline
- Obtained permission to be contacted about participating in a free local smoking cessation class Y__ N__
If yes, which language would you prefer? English_____ Spanish_____ Creole_____

Patient Name _____ Date _____

Referring Provider _____

Practice Name _____

Practice address _____ Zip Code _____

Telephone _____ Fax _____

PATIENT

Assistance from the Quit for Life Line will increase your chances for success in quitting tobacco.

The QuitLine provides:

- Friendly, respectful support
- No-pressure, helpful counseling
- Expertise in tobacco and nicotine
- Ways to boost your confidence

Best day and time for Quitline staff to call me:

Day _____ Time _____

My signature gives permission for my provider to FAX this form to the Florida Quit for Life Line. I understand that a Quitline specialist will call me within the next week.

Patient Signature _____

Patient telephone _____ Zip Code _____

FAX THIS FORM TO (877)747-9528

Questions? Call the Florida Quit for Life Line, 1-(877) U CAN NOW