



QUITLINE IOWA

1 800 QUIT NOW | 1 800 784 8669

Quitline Iowa Fax Form

Fax to: 800-261-6259

Date _____

PATIENT INFORMATION (PRINT CLEARLY)

Patient name (Last) _____, (First) _____

Date of birth _____

Gender M F

Initial _____

I am ready to quit tobacco and request that Quitline Iowa contact me to help with my quit plans.

I understand that the Quitline Iowa will inform my provider about my participation and quitting results.

Patient signature _____ Date _____

This release shall be valid for one year after the above date.

Address _____ City _____, IA Zip code _____

Phone #1 (____) _____ - _____ #2 (____) _____ - _____ E-mail _____

Best times to call morning afternoon weekend evening May we leave a message? Yes No

Language English Spanish; Other _____ Are you hearing impaired and need assistance? Yes No

PROVIDER INFORMATION (PRINT CLEARLY)

Provider name _____

Contact name _____

Clinic/Hosp/Dept _____

E-mail _____

Address _____

Phone (____) _____ - _____

City/State/Zip _____

Fax (____) _____ - _____

Provider consent is required to provide nicotine replacement therapy (NRT) to individuals who have certain medical conditions or are pregnant.

Please sign here if patient may use NRT.

Provider signature _____

Comments _____

PLEASE COMPLETE FORM AND FAX OR MAIL TO

FAX 1-800-261-6259

Quitline Iowa
National Jewish Medical and Research Center
1400 Jackson St., M305
Denver, CO 80206

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