PLAN FIRST/MEDICAID SMOKING CESSATION PROGRAM

PATIENT REFERRAL/CONSENT FORM FOR ALABAMA QUITLINE

Patient Information

Patient's Name: _____Medicaid # _____ Date: _____

Telephone #: _____ *Best Contact Time: _____ *Daytime _____ *Evening _____

I hereby authorize my healthcare provider to release my contact information and information regarding my tobacco use to the Alabama Tobacco Quitline. This authorization is continuing. I understand that the Alabama Tobacco Quitline will contact me to provide information, offer support in quitting tobacco and will provide progress reports to my healthcare provider. I agree to take part in this program and I understand that my participation is voluntary. I understand that any information I provide will be kept confidential.

Patient/Client Signature for Consent: _____

Comments: _____

Healthcare Provider

I request that the Alabama Tobacco Quitline, operated by National Jewish Health, contact my patient for the provision of tobacco cessation services.

Care Coordinator/ Referring Provider:

_____ _____

Print Name Signature

Facility/County Health Department Name: _____

Address:_____

Telephone #: _____ Fax#: _____ Date: _____

Quitline

Alabama Tobacco Quitline
1-800-QUIT-NOW
(1-800-784-8669)

Fax to **Alabama Tobacco Quitline: 1-800-261-6259**

For additional forms PLEASE COPY or visit http://www.adph.org/planfirst

*Quitline office hours: 7 days a week 6am-midnight

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