

Maine Tobacco HelpLine Referral

Provider Completes

Provider:	Practice:	
Address:		
Telephone:	Fax:	
<i>In referring this patient to the HelpLine, we have determined that he/she is interested in quitting tobacco, and that we have provided support and arranged follow-up.</i>		
Patient Name:	Birthdate:	
Street Address:		
City, State, Zip:	Phone:	
Medical History (check ALL that apply):		
<input type="checkbox"/> Asthma	<input type="checkbox"/> Chronic Kidney Disease	<input type="checkbox"/> Parent or Guardian of Child
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Depression	<input type="checkbox"/> Postpartum
<input type="checkbox"/> Chronic Heart Failure	<input type="checkbox"/> Stroke/TIA	<input type="checkbox"/> Partner of Pregnant Patient
<input type="checkbox"/> Chronic Obstructive Lung Disease	<input type="checkbox"/> Peripheral Arterial Disease	<input type="checkbox"/> Other:

Patient Completes

Assistance from the Maine Tobacco HelpLine will increase your chances for success in quitting tobacco.

Friendly, respectful support. No-pressure, helpful counseling.

I prefer to be called by the Maine Tobacco HelpLine (check your choices)

TIME: 9am – noon noon – 3pm 3 – 6pm 6 – 9pm

I authorize my Provider to release the information above to the Maine Tobacco HelpLine so he or she can contact me. I understand that my Provider may not condition treatment to me upon my signing this authorization, but that unless I sign this authorization my Provider will not be able to provide any of my protected health information to the Maine Tobacco HelpLine. I understand that I am entitled to a copy of this form and that the information will not be re-disclosed. I understand that I have a right to copy or inspect any information being disclosed. I understand that I may revoke this authorization by writing to my provider, if the information has not already been used. I understand that revocation may be the basis for denial of health benefits or other insurance coverage or benefits. This authorization expires in 30 months.

Signature of patient or patient's representative

Date

Printed name of patient's representative

Relationship to patient

VERBAL CONSENT OBTAINED BY: _____

Date

Questions? Call the Maine Tobacco HelpLine (800) 207-1230 or the Center for Tobacco Independence (207) 662-7154

Fax this form to (207) 662-5102

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