pennsylvania
DEPARTMENT OF HEALTH

Pennsylvania Free Quitline
Fax Referral Form
Fax Number: 1-800-261-6259

Provider Information: **Fax Sent Date:** _____/_____/_____

The Quitline is an entity that is compliant with the Health Insurance Portability and Accountability Act (HIPAA). The Quitline will only be able to share service outcome information with you if you verify that your organization is a HIPAA-covered entity and that the use of information is for treatment purposes as permitted by HIPAA.

Please indicate whether you are a HIPAA covered entity: **I am a HIPAA Covered Entity** ____Yes ____No

Health Care Provider: _____

Address: _____

Fax: (_____) _____ -_____ **Phone** (_____) _____ - _____

Participant Information: **Gender:____male ___ female** **If female, are you pregnant? ____Y ____N**

Participant Name: _____ **DOB:** _____/_____/_____

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

Primary #: (_____) _____- _____ **Type: ____ HM ____ WK ____ CELL ___OTHER**

Secondary #: (_____) _____ - _____ **Type: ____ HM ____ WK ____ CELL ___OTHER**

Language Preference (check one): _____ English _____ Spanish _____Other - _____

Tobacco Type (check ALL that apply): ____ Cigarettes ____ Smokeless Tobacco _____ Cigar _____ Pipe

_____I am ready to quit tobacco and request the Pennsylvania Free Quitline contact me to help me with my quit plan. **(Initial)**

_____ I give my permission to the Pennsylvania Free Quitline to leave a message when contacting me. **(Initial)**

Participant Signature: _____ **Date:** _____/_____/_____

The Pennsylvania Free Quitline will call you. Please check the BEST time frame for them to reach you. NOTE: The Quitline is open 7 days a week; call attempts over a weekend may be made at times other than during this time frame.

❑ 7am -10am **❑ 9am - 12pm** **❑ 12pm - 3pm** **❑ 3pm - 6pm** **❑ 6pm - 9pm**

Within this 3-hour time frame, please contact me at (check one): ___ Primary Phone ____ Secondary Phone

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