

Provider Information

Fax Number: 1-800-483-3114

Patient File Number: _____

Clinic Name: - ONSMS - _____

Fax Sent Date: _____ / _____ / _____

Health Care Provider: _____

Hospital Name: _____
(if applicable)

Contact Name: _____

I am a HIPAA-Covered Entity (Please check one)

Yes No I Don't Know

Comments:

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

Patient Information

Gender: Male Female Pregnant? Yes No

Patient name: _____ DOB: _____ / _____ / _____

Address: _____ City: _____ Zip: _____

Home:(_____)_____-_____- Work:(_____)_____-_____- Cell:(_____)_____-_____

Language Preference (check one): English Spanish Other_____

Tobacco Type (check primary use): Cigarettes Smokeless Tobacco Cigar Pipe

____ I am ready to quit tobacco and request the North Carolina Tobacco Use Quitline contact me to help me with my quit plan.
(Initial)

____ I DO NOT give my permission to the North Carolina Tobacco Use Quitline to leave a message when contacting me.
(Initial)

Patient Signature: _____ Date: _____ / _____ / _____

The North Carolina Tobacco Use Quitline will call you. Please check the BEST time frame for them to reach you.
NOTE: Quitline is open seven days a week; call attempts over a weekend may be made at times other than the time frame you select.

9am-12pm 12pm-3pm 3pm-6pm 6pm-9pm 9pm-12am 12am-3am

Within this time frame, please contact me at (circle one): home | work | cell



Double your chances of quitting for good.

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