1.800.QUIT.NOW (1-800-784-8669)

Colorado QuitLine 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 the Colorado QuitLine contact me to help with my quit plans.**

I understand that the Colorado QuitLine 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** ______________________, **CO** **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

Colorado QuitLine
National Jewish Health®
1400 Jackson St., M302
Denver, CO 80206

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