OKLAHOMA HELPLINE FAX REFERRAL FORM

Fax Number: 1-800-483-3114

FAX SENT DATE: _____/_____/_____

Provider Information:

CLINIC NAME CLINIC ZIP CODE

HEALTH CARE PROVIDER

Physician Nurse Clinic Staff

CONTACT NAME

FAX NUMBER PHONE NUMBER

I AM A HIPAA COVERED ENTITY (PLEASE CHECK ONE) ☐ YES ☐ NO ☐ DON'T KNOW

Patient Information:

PATIENT NAME DATE OF BIRTH GENDER ☐ MALE ☐ FEMALE

ADDRESS CITY ZIP CODE

PRIMARY PHONE NUMBER HM ☐ WK ☐ CELL ☐ SECONDARY PHONE NUMBER HM ☐ WK ☐ CELL ☐

LANGUAGE PREFERENCE (PLEASE CHECK ONE) ☐ ENGLISH ☐ SPANISH ☐ OTHER _____

_____ I am ready to quit tobacco and request the Oklahoma Tobacco Helpline contact me to help me with my quit plan.
(Initial)

_____ I DO NOT give my permission to the Oklahoma Tobacco Helpline to leave a message when contacting me.
(Initial) **By not initialing, you are giving your permission for the quitline to leave a message.

PATIENT SIGNATURE: _____ DATE: _____/_____/_____

The Oklahoma Tobacco Helpline will call you. Please check the BEST 3-hour time frame for them to reach you**. NOTE: The Helpline is open 7 days a week; call attempts over a weekend may be made at times other than during this 3-hour time frame.**

6AM – 9AM ☐ **9AM – 12PM** ☐ **12PM – 3 PM** ☐ **3PM – 6PM** ☐ **6PM – 9PM** ☐

WITHIN THIS 3-HOUR TIME FRAME, PLEASE CONTACT ME AT (CHECK ONE): Primary # ☐ **Secondary #** ☐

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