Quitline Iowa Provider Proactive Referral Form

Provider Section:

**FAX TO:**
Quitline Iowa
1-319-384-4841
(Phone: 319-384-4845)

**FROM:** (Stamp or write in contact information for referring agency here, please include FAX number & provider name)
Provider Name:
Referring Agency/Clinic/Hospital:
Provider Phone:
Provider Fax:

☐ I want referral outcome information.

Patient Section (please fill out this form and return it to your health care provider to fax to Quitline Iowa on your behalf):

☐ Yes, I want Quitline Iowa to help me quit smoking.

☐ By signing this form, I agree that:
  • My participation with Quitline Iowa is voluntary.
  • Quitline Iowa may contact me about quitting smoking, local programs, and/or counseling.
  • Quitline Iowa and my health care provider may discuss my use of the Quitline.
  • All of my information will be kept private.

__________________________________ __________________ ________________
Patient’s Name (please print)   Patient Signature (or Guardian if patient is under 18)

When would you like Quitline to call you? Please tell us the best times and days.

☐ 8:00 a.m. to noon
☐ Noon to 4:00 p.m.
☐ 4:00 p.m. to 8:00 p.m.
☐ 8:00 p.m. to midnight
☐ Please call me at this exact time: ______________
☐ These are the best days to call: ________________________________

☐ English speaker   ☐ Spanish speaker   ☐ Other language _____________
☐ Hearing impaired (need TDD)

Phone: (_____) _______________________
☐ home   ☐ work   ☐ other

May our counselors leave a message saying they are calling from Quitline Iowa?
☐ Yes   ☐ No

Adapted from: @2003 The State of Arizona, Arizona Department of Health Services Office of Tobacco Education and Prevention Program

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