1-800-QUIT NOW
QUITNOWNM.COM

NEW MEXICO FREE TOBACCO HELPLINE
FAX REFERRAL FORM
Fax Number: 1-800-483-3114

FAX SENT DATE: ____/____/____

Provider Information:

CLINIC NAME

CLINIC ZIP CODE

HEALTH CARE PROVIDER

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

By participating in this program I understand that outcome information may be shared with my provider for purposes of my treatment.

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

_____ I **DO NOT** give my permission to the New Mexico Free 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 New Mexico Free Tobacco Helpline will call you. Please check the BEST 3-hour 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 3-hour time frame.***

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

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