

Refer-to-Quit Referral Form

Fax form to: 1-866-QUIT-FAX (1-866-784-8329)



New York State
Smokers' Quitline
1-866-NY-QUITS (1-866-697-8487)
www.nyquitline.com



HEALTH REPUBLIC
INSURANCE OF NEW YORK

Step-by-Step:

- If a tobacco user would like help from the Quitline, complete form.
- Fax completed form to 1-866-784-8329.
- A Quitline Quit Coach will contact the tobacco user and offer free cessation services. A progress report will be sent to the provider listed on this form.
- The Quitline program is a free service for all New York State residents regardless of insurance status.

Code: **HRINY**
Special Programs Only

Tobacco Users: Complete This Section

(Please print)

First Name _____ Last Name _____ Date of Birth ____ / ____ / ____

Mailing Address _____ City _____ State _____ Zip Code _____

☐ Male ☐ Female Gender () _____ - _____ () _____ - _____
Primary Phone (area code + number) Secondary Phone (Area code + number)

E-mail Address: _____

When should we call? ☐ Morning ☐ Afternoon ☐ Evening ☐ No preference May we leave a message? ☐ Yes ☐ No

Language Preference: ☐ English ☐ Spanish ☐ Other (specify) _____

I (undersigned) give permission for the support staff of the New York State Smokers' Quitline to contact me, coach me in quitting smoking, and give feedback regarding my progress to the health care provider listed below and permission for that provider to forward the information to other relevant health care providers.

Required Tobacco User's Signature (or agent if authorization was verbal) _____

Date _____

Health Providers/Employer/Other: Complete This Section

Referrer: _____ () _____ - _____
Phone number

Facility: _____ () _____ - _____
Fax number

Address: _____ City _____ State _____ Zip _____

E-mail address: _____

SEND PROGRESS REPORT VIA SECURED: ☐ Secured Site Access ☐ E-mail (Secured Attachment)
☐ Fax (Provider Secured) ☐ DO NOT SEND PROGRESS REPORT

If a selection is not indicated, no progress reports will be made available.

Send feedback report to:

☐ Same as above or _____ () _____ - _____
Name Phone number

Facility _____ () _____ - _____
Fax number

E-mail address: _____

PEDIATRICS ONLY: Tobacco Users' relationship to child: ☐ Mother ☐ Father ☐ Other (specify) _____
Child/Children's name: (to help with recordkeeping) _____