

**PLEASE  
PRINT  
CLEARLY**



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317 George Street, Suite 210, New Brunswick, NJ 08901  
Phone: 732-235-8222; Fax: 732-235-8298  
[www.tobaccoprogram.org](http://www.tobaccoprogram.org)

## FAX-TO-QUIT REFERRAL FORM

- STEP 1:** Provider fills out top portion of referral form
- STEP 2:** Patient fills out contact information and signs form
- STEP 3:** Provider makes copy for patient
- STEP 4:** Provider faxes form to the Tobacco Dependence Clinic at **732-235-8298**

**Provider**

1. Patient's Name: \_\_\_\_\_
2. Referring Provider: \_\_\_\_\_
3. Referring Facility: \_\_\_\_\_
4. Provider/Facility Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_, ext. \_\_\_\_\_
5. Check if Patient is Spanish-speaking ONLY \_\_\_\_\_

**Patient**

- I would like help to stop using tobacco and I give my permission to my health care provider to fax this information to the Tobacco Dependence Clinic.**
- I understand that a Counselor will call me within the next week.**

Patient Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_

**The Tobacco Dependence Clinic will call you.**

Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Alternate Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Please check the best times for the Clinic to reach you.**

Morning  Afternoon  Evening

**If you are unavailable when we call you, may we leave a message, identifying ourselves as the Tobacco Dependence Clinic?**

Yes  No

**Please write any additional information here (e.g. your address etc):**

\_\_\_\_\_  
\_\_\_\_\_