



New Jersey Quit Line FAX Referral Form
Fax Number: 1-800-483-3114

Provider Information:

Fax Sent Date: ___/___/___

Clinic Name: _____

Health Care Provider: _____

Contact Name: _____

I am a HIPAA-Covered Entity (Please check one) ___ Yes ___ No ___ I Don't Know

Fax: (_____) _____ - _____ Phone _____

Comments:

Patient Information:

Gender: ___ male / ___ female Pregnant? ___ Y ___ N

Patient Name: _____ DOB: ___/___/___

Address: _____ City: _____ Zip: _____

Primary #: (_____) _____ - _____ Type: ___ HM ___ WK ___ CELL ___ OTHER

Secondary #: (_____) _____ - _____ Type: ___ HM ___ WK ___ CELL ___ OTHER

Language Preference (check one): ___ English ___ Spanish ___ Other - _____

Tobacco Type (check ALL that apply): ___ Cigarettes ___ Smokeless Tobacco ___ Cigar ___ Pipe

____ I am ready to quit tobacco and request the New Jersey Quitline contact me to help me with my quit plan. (Initial)

____ I DO NOT give my permission to the New Jersey Quitline to leave a message when contacting me. (Initial)

Patient Signature: _____ Date: ___/___/___

The New Jersey Quitline 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