

Ohio Department of Health
Quit Line Referral

ODH Grantee ID: <i>if available</i>

Referring provider

Use stamp, label or write in information below.

Name		Phone ()	
Clinic/Facility		FAX* ()	
Address			
City	State	ZIP	

*Required in order to receive confirmation of referral.

Participant information

Name		Date of birth / /	
Address			
City	State	ZIP	
Preferred phone ()	Best time and day to call	Do you need TTY? <input type="checkbox"/> Yes <input type="checkbox"/> No	May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No

Note: Participant signature required on bottom portion in order to place an initial phone call to the participant.

This patient may use nicotine replacement therapy.

Provider signature	Date / /
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Consent for release of information

I, _____, participant name give permission to my healthcare provider, the Ohio Department of Health or its contractors, to release information about my interest and participation in the Ohio Tobacco QUIT LINE Program to and from National Jewish Medical and Research Center (contractor for the Ohio Tobacco QUIT LINE).

The purpose of this release is to request that National Jewish Medical and Research Center make an initial phone call to me to discuss participation in the Ohio Tobacco QUIT LINE Stop Tobacco Use Program.

Required

Signature of participant	Date / /
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Please fax this form to: QUIT LINE Referral Specialist, **800-261-6259**

For questions, please contact: **1-800-QUIT-NOW (800-784-8669)**

QUIT LINE services are funded by the Ohio Department of Health