Robert Wood Johnson University Hospital Somerset | RWJBarnabas HEALTH

Phone: 908-685-2442 Fax**:** 908-685-2548

PLEASE PRINT CLEARLY

FAX-TO-QUIT OUTPATIENT 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 faxes form to the Tobacco Quitcenter at **908-685-2548**

Provider

1. Patient's Name: _____DOB: __/___/____

2. Referring Provider/Facility: _____Provider Phone #_____

3. List Medical Diagnoses and/or prescription drugs affected by smoking: *

_____

4. List other symptoms related to smoking (e.g., cough, shortness of breath): *

_____

*Please complete this information, which is necessary for insurance reimbursement.

Physician or APN Signature: _____Date: _____

Patient

Patient Signature: _____

Today's Date: _____

The Tobacco Quitcenter will call you.

Best 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 Quitcenter?

_____Yes _____No

Please write any additional information here (e.g. if you prefer receiving text messages, contact at your email or mail at your home address, etc):

_____

_____