



Tobacco Treatment Enrollment Form

1-866-QUIT-YES

1 - 8 6 6 - 7 8 4 - 8 9 3 7
TTY for Hearing Impaired 1-800-501-1068

Where Quitters Always Win!

PATIENT INFORMATION – Please Print

FIRST NAME		LAST NAME	
MAILING ADDRESS		CITY/ COUNTY	STATE ZIP
EMAIL ADDRESS		DATE of BIRTH	PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO
PHONE NUMBER (Area Code) + Number ()		ALTERNATE PHONE (Cell, Work Etc.) ()	HFS PARTICIPANT <input type="checkbox"/> YES <input type="checkbox"/> NO
MAY WE LEAVE A MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO		PREFERENCE ENGLISH SPANISH OTHER (SPECIFY):	

WHEN SHOULD WE CALL? 7 am – 10 am 10 am – 1 pm 1 pm – 4 pm 4 pm – 7 pm 7 pm – 9 pm
(Please Circle One)

THE QUITLINE TYPICALLY CALLS THE PATIENT BACK WITHIN ONE BUSINESS DAY OF RECEIVING A REFERRAL.

PATIENT SIGNATURE – El paciente firma a continuación

I hereby authorize my provider to release the information on this enrollment form to the Illinois Tobacco Quitline for purposes of my participation in the tobacco cessation program. I also authorize the Illinois Tobacco Quitline and its representatives to contact me at the phone number(s) I have listed above upon receiving this referral from my provider. I give the Quitline and the referring agency permission to discuss my use of service.

Yo por este medio autorizo a mi proveedor que revele la información en este formulario de inscripción a la Línea para Dejar de Fumar en Illinois para participar en el programa para dejar de fumar. Yo también autorizo a la Línea para Dejar de Fumar en Illinois y sus representantes que se comuniquen conmigo al número de teléfono(s) que he provisto arriba, al recibir esta referencia de mi proveedor. Doy el Quitline y el permiso de la agencia que se refiere de discutir mi uso del servicio

X SIGNATURE OF THE PATIENT OR PATIENT'S REPRESENTATIVE FIRMA DEL PACIENTE O REPRESENTANTE DEL PACIENTE		DATE FECHA
PRINT NAME: NOMBRE DEL REPRESENTANTE DEL PACIENTE EN LETRA DE MOLDE		RELATIONSHIP TO PATIENT PARENTESCO CON EL PACIENTE

HEALTHCARE PROFESSIONAL TOBACCO TREATMENT CHECKLIST

1. ASK <i>about use</i> Identify and document patient's tobacco use.	2. ADVISE <i>to quit</i> In a clear, strong personalized manner, urge patient to quit.	3. ASSESS <i>readiness to quit</i> Is patient willing to make an attempt?	4. ASSIST <i>in quit attempt</i> Suggest counseling or pharmacotherapy to assist in quit.	5. ARRANGE <i>follow up</i> By faxing this form, the Illinois Tobacco Quitline will follow-up.
ASSESSMENT of readiness to quit:	<input type="checkbox"/> Ready to quit <input type="checkbox"/> Thinking about quitting <input type="checkbox"/> Not ready to quit		Current level of tobacco use _____	
ASSISTANCE to quit:	Is Chantix appropriate? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please provide patient with prescription) Is Bupropion appropriate? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please provide patient with prescription) Is Nicotine Replacement appropriate? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Medicaid, please provide patient with prescription)			
ADDITIONAL COMMENTS:				

In collaboration with:



Breathing Freedom
"Working Together to Live Tobacco Free"

Clinician Signature X _____

Printed Name: _____

Phone or Email: _____

FAX FORM TO: 217-787-5916