



## Tennessee Tobacco QuitLine Fax Referral Service Enrollment Form

### Health Care Provider Information – Please Print

Health Care Provider (First, Last, Title):	
Organization:	
Fax Number: (    )                      -	
Phone: (    )                      -	Email:
Have you discussed this tobacco cessation program with the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

### Patient Information – Please Print

First Name:	Last Name:	Middle Initial:
Mailing Address (city, state, zip):		
Phone Number: (    )		May We Leave A Message? <input type="checkbox"/> Yes <input type="checkbox"/> No
Alternate Phone Number: (    )		
Email (if applicable):		
Language Preference (Check One): <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:		
The Tennessee Tobacco QuitLine staff can call me during the following times (check all that apply).		
<input type="checkbox"/> Central Standard Time <input type="checkbox"/> East Standard Time		
<input type="checkbox"/> 7am- 10am <input type="checkbox"/> 10am – 1pm <input type="checkbox"/> 1pm – 4pm <input type="checkbox"/> 4pm – 7pm <input type="checkbox"/> 7pm – 9pm		
I give my consent for the Tennessee Tobacco QuitLine to call me. (Patient Signature):		

**Fax to: 1-800-646-1103**

*Confidentiality Notice: This facsimile contains confidential information. If you have received this facsimile in error, please notify the sender immediately by telephone and confidentially dispose of the material. Do not review, disclose, copy, or distribute.*



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