



Colorado QuitLine Fax Form
Fax to: 800-261-6259

1.800.QUIT.NOW (1-800-784-8669)

Date _____

PATIENT INFORMATION (PRINT CLEARLY)	
Patient name (Last) _____, (First) _____	Date of birth _____ Gender <input type="checkbox"/> M <input type="checkbox"/> F
<i>Initial</i> _____ I am ready to quit tobacco and request that the Colorado QuitLine contact me to help with my quit plans.	
I understand that the Colorado QuitLine will inform my provider about my participation and quitting results.	
Patient signature _____	Date _____
<i>This release shall be valid for one year after the above date.</i>	
Address _____	City _____, CO Zip code _____
Phone #1 (____) _____ - _____	#2 (____) _____ - _____ E-mail _____
Best times to call <input type="checkbox"/> morning <input type="checkbox"/> afternoon <input type="checkbox"/> weekend <input type="checkbox"/> evening May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Language <input type="checkbox"/> English <input type="checkbox"/> Spanish; Other _____ Are you hearing impaired and need assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No	

PROVIDER INFORMATION (PRINT CLEARLY)	
Provider name _____	Contact name _____
Clinic/Hosp/Dept _____	E-mail _____
Address _____	Phone (____) _____ - _____
City/State/Zip _____	Fax (____) _____ - _____
Provider consent is required to provide nicotine replacement therapy (NRT) to individuals who have certain medical conditions or are pregnant.	
Please sign here if patient may use NRT. _____ <i>Provider signature</i>	
Comments _____	

PLEASE COMPLETE FORM AND FAX OR MAIL TO

FAX 1-800-261-6259

Colorado QuitLine
National Jewish Medical and Research Center
1400 Jackson St., M305
Denver, CO 80206

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