**I. Provider Information (Required)** *Provider fills out. Select Hospital or Non-Hospital. See examples on back.*

|  |  |
| --- | --- |
| [ ]  **HOSPITAL** | [ ]  **NON-HOSPITAL** |
| Health System: |  | Umbrella Organization: |  |
| Hospital Name: |  | Clinic/Agency: |  |
| Department: |  | Dept/Location: |   |
| Provider Name: |  | Provider Name: |  |
| Main Contact Person:  |  | Email: |  |
| Phone:  |  | Fax: |  |
| Address:  |  | City: |  |  State: |  |  Zip Code: |  |
| I am a HIPAA Covered Entity and I want a feedback report: [ ]  Yes [ ]  No  |

**II. Patient Information (Required)** *Patient fills out*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Patient First Name:  |  |  Patient Last Name:  |  |  Date of Birth: |  |
| Address: |  | City: |  |
| State: |  | Zip Code: |  | County: |  |
| Email: |  |
| Best Phone Number: |  | Alternate Phone Number: |  |

The best time to call you: *(check one)*

 [ ]  Morning: 8am – Noon [ ]  Afternoon: Noon – 5pm [ ]  Evening: 5 – 9pm [ ]  Anytime

Can we leave a voicemail? *(check one)*

 [ ]  Yes [ ]  No

*My signature gives permission for my provider to send this form to a Tobacco Free Florida representative.*

*I understand that I will be contacted within the next week.*

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Signature: |  |  Date: |  |

***Program Choice:*** *Check* ***ONE*** *box below (see program descriptions on back). The provider will then submit this form via fax or email to the program listed below.*

|  |  |  |
| --- | --- | --- |
| [ ]  |  Attend an in-person group or virtual class | ***Fax:*** *1-888-975-1534* | ***Email:*** *tobacco@ahec.ufl.edu* |
| [ ]  |  Talk to a Quit Coach® over the phone | ***Fax:*** *1-866-688-7577* | ***Email:*** *supportservices@optum.com* |

Referral Form Submission Instructions

1. Provider Information: The provider completes this section. Examples are listed below:

|  |  |  |  |
| --- | --- | --- | --- |
| Hospitals | Example 1 | Example 2 | Example 3 |
| Health System: | UF Health | Memorial Healthcare System | Flagler Health |
| Hospital Name: | Shands Hospital | Memorial Hospital Pembroke | Flagler Hospital |
| Department: | Internal Medicine | Respiratory Therapy | Cardiopulmonary |
| Provider Name: | John Doe |  | Jane Smith |
| Non-hospitals | Example 1 | Example 2 | Example 3 |
| UmbrellaOrganization: | Walgreens |  |  |
| Clinic/Agency: | Walgreens | Santa Rosa County Health Department | Juan Pérez, D.O. Smith, D.O. |
| Dept/Location: | #1234 |  |  |
| Provider Name: | John Doe | Jane Doe | Juan Pérez, D.O. |

II. Patient Information: The patient provides their contact information.

 *Program Choice*: Patient should select ONE program from the list.

* Provider should fax or email completed forms to the program the patient has selected.
* If the referral is sent to the in-person group or virtual group class, the patient will be called by the Florida Area Health Education Center (AHEC) that serves the patient’s county to schedule them in a course.
* If the referral is sent to the telephone program, a tobacco Quit Coach will call the patient to enroll them in their preferred program.

|  |
| --- |
| **Tobacco Free Florida Program Options** |
| **Group (Virtual) Quit**Register for a session with trained facilitators along with others who want to quit like you. * Led by a trained specialist
* 2 to 4 weeks nicotine patches, gum or lozenges
* Convenient times & locations
* Group support
 | **Phone Quit**A Quit Coach® is waiting for your call to help you on your journey to be tobacco free.* Quit Coach® 24/7
* 2 weeks nicotine patches or gum
* Custom plan
* 3 calls from Quit Coach®
* 1-877-U-CAN-NOW (1-877-822-6669)
 |
| ***Need more information about the programs available? Visit:*** https://tobaccofreeflorida.com/how-to-quit-tobacco/smoking-cessation-programs |