



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

PATIENT INFORMATION – Please Print

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

WHEN SHOULD WE CALL?

Please Circle One: 7 am – 10 am 10 am – 1 pm 1 pm – 4 pm 4 pm – 7 pm 7 pm – 9 pm

THE QUITLINE USUALLY 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
X PRINTED NAME OF PATIENT REPRESENTATIVE NOMBRE DEL REPRESENTANTE DEL PACIENTE EN LETRA DE MOLDE		RELATIONSHIP TO PATIENT PARENTESCO CON EL PACIENTE

HEALTHCARE PROFESSIONAL TOBACCO TREATMENT CHECKLIST

1. ASK about use Identify and document patient's tobacco use.	2. ADVISE to quit In a clear, strong personalized manner, urge patient to quit.	3. ASSESS readiness to quit Is patient willing to make an attempt?	4. ASSIST in quit attempt Suggest counseling or pharmacotherapy to assist in quit.	5. ARRANGE follow up 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			
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)			

<input type="checkbox"/>	Clinic Name: _____ Phone: (_____) _____	FAX THIS FORM TO: Illinois Tobacco Quitline 217-787-5916
<input type="checkbox"/>	Signature of Clinic Personnel: _____	