

Tobacco LIVE FREE OR DIE

NH TOBACCO PREVENTION & CONTROL PROGRAM
 Dept. of Health & Human Services • Division of Public Health Svcs.
 29 Hazen Drive, Concord, NH 03301 • 603-271-6891

For Provider Use Only
 (Patient stamp, label, or info. (name, record number/DOB, date))

Tobacco Treatment Enrollment

A Project of the NH Department of Health and Human Services

TOBACCO TREATMENT CHECKLIST

- ADVISE** smoker to stop: Stop-smoking advice given: “I strongly advise you to quit smoking and I can help you.”
- ASSESS** readiness to quit: Ready to quit? Thinking about quitting? Not ready to quit?
- ASSIST** smoker to quit: Brief counseling. Discuss: •Reasons to quit •Barriers to quitting
 •Lessons from past quit attempts •Set a quit date, if ready •Enlist social support
- Medications. If appropriate, recommend: (CIRCLE): patch gum lozenge
 inhaler nasal spray Bupropion (Zyban®/Wellbutrin®)
- ARRANGE** follow-up: Refer to New Hampshire Smokers’ Helpline by faxing the lower portion of this form
 toll free to **1-866-560-9113**

NEW HAMPSHIRE SMOKERS’ HELPLINE
 Fax this part of form toll-free to **1-866-560-9113**

New Hampshire Resident Enrollment Form

Referral Source

Referred by: Name _____	Phone (area code + number) ()
Facility _____	
Address _____ _____	

Patient Information

First Name _____	Last Name _____	Date of Birth (month/day/year) _____
Primary Insurance: <input type="checkbox"/> Cigna <input type="checkbox"/> Anthem Blue Cross/Blue Shield <input type="checkbox"/> Harvard Pilgrim <input type="checkbox"/> Un-insured <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Delta Dental <input type="checkbox"/> HealthTrust <input type="checkbox"/> Other		
Address: _____ NH _____		
Street _____	City _____	Zip _____
Phone (area code + number) ()	May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	Language preference <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____

When Should We Call? Check all that apply. morning afternoon evening no preference

I authorize my healthcare provider (“Provider”) to release the information on this enrollment form to the Try-To-STOP TOBACCO Resource Center of New Hampshire (“Resource Center”) for purposes of my participation in the Resource Center program. I also authorize the Resource Center and its representatives to contact me upon receiving this referral from my healthcare provider.

Signature of Resource Center Client or Client’s Representative

Date

Printed Name of Resource Center Client or Client’s Representative

Date