Department of Health
Tobacco Use Prevention and Cessation Program

OHIO TOBACCO **QUIT** LINE REFERRAL
FAX: **800-261-6259**

Ohio Department of Health
Quit Line Referral

ODH Grantee ID: *if available*

Referring provider
Use stamp, label or write in information below.

Name		Phone ( )
Clinic/Facility		FAX* ( )
Address		
City	State	ZIP

*Required in order to receive confirmation of referral.

Participant information

Name		Date of birth / /
Address		
City	State	ZIP

Preferred phone ( )	Best time and day to call	Do you need TTY? ☐ Yes ☐ No	May we leave a message? ☐ Yes ☐ No

Note: Participant signature required on bottom portion in order to place an initial phone call to the participant.

This patient may use nicotine replacement therapy.

Provider signature	Date / /

Consent for release of information

I, _____ (*participant name*), give permission to my healthcare provider, the Ohio Department of Health or its contractors, to release information about my interest and participation in the Ohio Tobacco **QUIT** LINE Program to and from National Jewish Medical and Research Center (contractor for the Ohio Tobacco **QUIT** LINE).

The purpose of this release is to request that National Jewish Medical and Research Center make an initial phone call to me to discuss participation in the Ohio Tobacco **QUIT** LINE Stop Tobacco Use Program.

Required

Signature of participant	Date / /

Please fax this form to: **QUIT** LINE Referral Specialist, **800-261-6259**
For questions, please contact: **1-800-QUIT-NOW (**800-784-8669)

QUIT LINE services are funded by the Ohio Department of Health

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Healthy Ohio
The State of Living Well.