Tobacco Treatment Program Referral Form

District Health Department #10
Healthy People, Healthy Communities

Today's Date _____

Patient is: ☐ **ready to quit** ☐ **already quit/needs support** ☐ **wants resources only**

Person making referral please complete

Agency name: _____ Contact Name: _____

E-mail: _____

Address City/Zip: _____

Phone: (_____)_____ Fax: (_____)_____

Provider has completed the 5A's Assessment with patient:

☐ **Yes** ☐ **No**

Does patient have any of the following conditions?

☐ **Pregnant/Postpartum** ☐ **Uncontrolled high blood pressure** ☐ **Heart disease**

Patient Information

Patient Name: _____

Address: _____

City/Zip code: _____

Date of Birth: _____/_____/_____ E-mail: _____

Phone: (_____)_____ 2nd phone: (_____)_____

Gender: ☐ Male ☐ Female

Language: ☐ English ☐ Spanish ☐ Other _____

Best times to call? ☐ morning ☐ afternoon ☐ evening

May we leave a message? ☐ Yes ☐ No

_____ *Client verbally consents to being contacted by a Tobacco Treatment Specialist*

Practitioner Initials

For DHD#10 Ten-county Region, PLEASE FAX To: 231-305-0005
Crawford, Kalkaska, Lake, Manistee, Mason, Mecosta, Missaukee, Newaygo, Oceana, or Wexford Counties