

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: (____) _____

Does patient have any of the following conditions?

Pregnant 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 **May we text?** Yes No

Client verbally consents to being contacted by a Tobacco Treatment Specialist

*Practitioner
Initials*

PLEASE FAX or EMAIL TO:

Mecosta/Newaygo: (231) 796-7864 or lmorris@dhd10.org

Manistee/Lake: (231) 723-1477 or hjoseph@dhd10.org

Mason/Oceana: (231) 845-0438 or grichardson@dhd10.org

Crawford/Kalkaska/Wexford/Missaukee: (231) 775-6693 or agullekson@dhd10.org

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12/2021 (CR)