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

PLEASE FAX or EMAIL TO:
Crawford/Kalkaska: (989) 348-5346 or msorenson@dhd10.org
Lake/Manistee: (231) 723-1477 or gkierczynski@dhd10org
Mason/Oceana (231) 845-0438 or grichardson@dhd10.org
Missaukee/Wexford (231) 775-5372 or agullekson@dhd10.org
Mecosta/Newaygo (231) 796-7864 or lmorris@dhd10.org