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** ☐ **Uncontrolled high blood pressure** ☐ **Heart disease**

Patient Information

Patient Name: ____

Address: ____

City/Zip code: ______________________________________ County:________________

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

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

Gender: ☐ Male ☐ Female ☐ Other

Language: ☐ English ☐ Spanish ☐ Other ____________________

Best times to call? ☐ morning ☐ afternoon ☐ evening

May we leave a message? ☐ Yes ☐ No **Text Apt Reminder?** ☐ 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

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