

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

Is this a referral for the N-O-T youth cessation program? Yes No

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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