



1-866-QUIT-YES

Tobacco Treatment Enrollment Form

PATIENT INFORMATION – Please Print

FIRST NAME		LAST NAME			
MAILING ADDRESS		CITY/ COUNTY		STATE	ZIP
EMAIL ADDRESS		DATE of BIRTH	PREGNANT		MEDICAID/SCHIP
			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
PHONE NUMBER (Area Code) + Number ()		ALTERNATE PHONE NUMBER ()			
MAY WE LEAVE A MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO		LANGUAGE PREFERENCE (Circle One) ENGLISH SPANISH OTHER (SPECIFY): _____			

THE QUITLINE USUALLY CALLS THE PATIENT BACK WITHIN ONE BUSINESS DAY OF RECEIVING A REFERRAL. WHEN SHOULD WE CALL?

Circle One: 7 am – 10 am 10 am – 1 pm 1 pm – 4 pm 4 pm – 7 pm

Patient to sign below / El paciente firma a continuación:

I hereby authorize my provider to release the information on this enrollment form to the Illinois Tobacco Quitline for purposes of my participation in the smoking cessation program. I also authorize the Illinois Tobacco Quitline and its representatives to contact me at the phone number(s) I have listed above upon receiving this referral from my provider.

Yo por este medio autorizo a mi proveedor que revele la información en este formulario de inscripción a la Línea para Dejar de Fumar en Illinois para participar en el programa para dejar de fumar. Yo también autorizo a la Línea para Dejar de Fumar en Illinois y sus representantes que se comuniquen conmigo al número de teléfono(s) que he provisto arriba, al recibir esta referencia de mi proveedor.

SIGNATURE OF THE PATIENT OR PATIENT'S REPRESENTATIVE FIRMA DEL PACIENTE O REPRESENTANTE DEL PACIENTE		DATE FECHA
PRINTED NAME OF PATIENT REPRESENTATIVE NOMBRE DEL REPRESENTANTE DEL PACIENTE EN LETRA DE MOLDE		RELATIONSHIP TO PATIENT PARENTESCO CON EL PACIENTE

TOBACCO TREATMENT CHECKLIST

Healthcare Professional to Complete the Following:

ASSESSMENT of readiness to quit:	<input type="checkbox"/> Ready to quit <input type="checkbox"/> Thinking about quitting <input type="checkbox"/> Not ready to quit Current level of tobacco use _____
ASSISTANCE to quit:	Would medication be appropriate? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, needs prescription for Zyban. Would Nicotine Replacement be appropriate? <input type="checkbox"/> Yes <input type="checkbox"/> No
CLINIC NAME: Signature of Clinic Personnel:	PHONE NUMBER: FAX NUMBER:

FAX THIS FORM TO: 217-787-5916