



Arkansas Tobacco Quitline  
 Fax Referral Form  
 Fax Number: 1-888-827-7057



Arkansas Department of Health

Fax Sent Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Clinic/Employer /Organization Name: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Referring Organization's Fax: (\_\_\_\_) \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**Health Care Provider Information:** The Arkansas Tobacco Quitline is an entity that is compliant with the Health Insurance Portability and Accountability Act (HIPAA). The Quitline will only be able to share service outcome information with you as the provider if you verify that your organization is a HIPAA-covered entity and that the use of information is for treatment purposes as permitted by HIPAA.

**The 2 A's and R for Health Care Providers**

- ✓ **ASK** what form of tobacco use & frequency
- ✓ **ADVISE:** to quit and discuss relevance, risks, roadblocks & rewards
- ✓ **REFER:** to the Arkansas Tobacco Quitline

*Please indicate whether your organization is a HIPAA covered entity:*  
 My organization is a HIPAA Covered Entity. \_\_\_\_ Yes \_\_\_\_ No

Name of Physician or Health Care Provider: \_\_\_\_\_

**Participant Information:** Gender: \_\_\_\_ Male \_\_\_\_ Female Pregnant? \_\_\_\_ Yes \_\_\_\_ No

Participant Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_, AR Zip: \_\_\_\_\_

Primary Phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ TYPE: \_\_\_\_ Home \_\_\_\_ Work \_\_\_\_ Cell \_\_\_\_ Other

Secondary Phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ TYPE: \_\_\_\_ Home \_\_\_\_ Work \_\_\_\_ Cell \_\_\_\_ Other

Language Preference (check one): \_\_\_\_ English \_\_\_\_ Spanish \_\_\_\_ Other: \_\_\_\_\_

Tobacco Type (check ALL that apply): \_\_\_\_ Cigarettes \_\_\_\_ Smokeless \_\_\_\_ Cigars \_\_\_\_ Pipe \_\_\_\_ E-Cig/ESDs

\_\_\_\_ I am ready to quit tobacco and request the Arkansas Tobacco Quitline contact me to develop my quit plan.  
 (Initial)

\_\_\_\_ I give my permission to the Arkansas Tobacco Quitline to leave a message when contacting me.  
 (Initial)

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Obtained by: \_\_\_\_\_

The Arkansas Tobacco Quitline will call you. Please check the BEST time frame for the Quitline to reach you.  
 7am - 9am     9am - 12 Noon     12 Noon - 3pm     3pm - 6pm     6pm - 9pm

Within the above time frame, please contact me at (check one): \_\_\_\_ Primary Phone \_\_\_\_ Secondary Phone

NOTE: The Arkansas Quitline is open 7 days a week. Call attempts on Saturday or Sunday may be made during time frames other than the one you select above.



**Confidentiality Notice: This facsimile contains confidential information.**  
 If you have received this facsimile in error, please notify the sender immediately by calling the contact person listed at the top of this form and confidentially dispose of the material.  
**Do not review, disclose, copy, or distribute.**

