Advocate Condell Medical Center

Tobacco Counseling Referral

TOBACCO FREE LAKE COUNTY

Lake County Health Department and Community Health Center

Fax: 847.984.5698

Phone: 847.377.8090 Email: TFLC@lakecountyil.gov

PATIENT INFORMATION – Please print		
Patient Name		Date of Birth
Address	City/State	Zip
Phone Number (area code) + number ( )	Alternate Phone (cell, work, etc.) ( )	
Race/Ethnicity ☐ White/non-Latino ☐ Latino ☐ African American ☐ Other:	Language Preference (circle one) ☐ English ☐ Spanish ☐ Other:	Best time to call? ☐ 9 am – 11 am ☐ 11 am – 1 pm ☐ 1 pm – 4 pm Can we leave a message? ☐ Yes ☐ No

PATIENT PERMISSION

I hereby authorize my provider to release the information on this enrollment form to the Tobacco Free Lake County (TFLC) program and/or the Illinois Tobacco Quitline (ITQ) for purposes of my participation in a tobacco cessation program. I also authorize TFLC and/or the ITQ to contact me at the phone number(s) I have listed above upon receiving this referral from my provider. I give TFLC and/or the ITQ and the referring agency permission to discuss my use of service.

Patient Signature:

HEALTHCARE PROFESSIONAL Questions for Interested Quitter		
On a Scale of 1 – 5, how ready are you now to quit your tobacco use? (1= not ready, 5=extremely ready) (Please circle) **1 2 3 4 5**	**What type of assistance are you interested in receiving to quit tobacco use?** ☐ Individual/1:1 counseling ☐ Group counseling ☐ Either of the above ☐ Illinois Tobacco Quitline (phone only) (see reverse side for ITQ fax form)	**What tobacco product do you currently use:** ☐ Cigarettes ☐ Smokeless tobacco/Chew ☐ E-Cigarettes
Primary Care Provider Contact Information: Provider Name (Print)	Phone	
Clinic Name/Address	City	

Created By: S. Christ
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State of Illinois
Illinois Department of Public Health

ILLINOIS TOBACCO QUITLINE
ILLINOIS DEPARTMENT OF PUBLIC HEALTH
AMERICAN LUNG ASSOCIATION OF ILLINOIS
Where Quitters Always Win!

Tobacco Treatment Enrollment Form

1 - 866 - QUIT - YES
1 - 866 - 784 - 8937
TTY for Hearing Impaired 1-800-501-1068

PATIENT INFORMATION -- Please Print and Stay in the Boxes

FIRST NAME

LAST NAME

MAILING ADDRESS

CITY STATE ZIP

EMAIL ADDRESS

PHONE NUMBER ( ) -

ALTERNATE PHONE ( ) -

DATE OF BIRTH / /

GENDER
☐ MALE ☐ FEMALE

RACE / ETHNICITY

LANGUAGE
☐ ENGLISH ☐ SPANISH ☐ OTHER (Specify)

PREGNANT
☐ YES ☐ NO

HFS PARTICIPANT
☐ YES ☐ NO

MAY WE LEAVE A MESSAGE?
☐ YES ☐ NO

WHEN SHOULD WE CALL?
☐ 7 am - 10am ☐ 10am - 1pm ☐ 1pm - 4pm ☐ 4pm - 7pm ☐ 7pm - 9pm ☐ 9pm - 11pm

PATIENT SIGNATURE

I authorize my provider to release the information on this enrollment form to the Illinois Tobacco Quitline for purposes of my participation in the tobacco cessation program and also authorize the Illinois Tobacco Quitline and its representatives to contact me at the phone number(s) I have listed above. I give the Quitline and the referring agency permission to discuss my use of service.

X _____ _____
SIGNATURE OF THE PATIENT OR PATIENT'S REPRESENTATIVE — DATE

X _____ _____
PRINTED NAME OF PATIENT REPRESENTATIVE — RELATIONSHIP TO PATIENT

HEALTHCARE PROFESSIONAL

LakeCounty
Health Department and
Community Health Center

Tobacco Free Lake County

SIGNATURE of Clinic Personnel:

X _____

7 6 6 5 7 5 FAX THIS FORM TO: 1 - 855 - QUIT - FAX (1 - 855 - 784 - 8329)

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