

# Maine Tobacco Helpline Referral Form

Date sent: \_\_\_/\_\_\_/\_\_\_

**Please fax completed form to 662-5102.**

## Information About Clinician Making Referral

Practice/Hospital: \_\_\_\_\_

Clinician Making Referral: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## Information About Patient/Client Being Referred

Patient/Client: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone where you can be reached: \_\_\_\_\_ Will you need translation services? Yes No

Male Female

Deaf/TTY Language (specify): \_\_\_\_\_

If inpatient, please included estimated discharge date: \_\_\_/\_\_\_/\_\_\_

**Please check the BEST time frame for the Helpline to reach you, Monday-Friday.**

8am-12pm

12pm-3pm

3pm-6pm

**If we don't reach you, we will leave a message with a call back number.  
Check this box if you do not want a message left**

**\*\*By faxing this form to the Maine Tobacco Helpline, I am confirming that the above patient/client has given consent to be called by the Maine Tobacco Helpline.\*\***



**Questions?** Call the Maine Tobacco Helpline at 1-800-207-1230