**Franklin County, PA FREE Quitline**
**PATIENT FAX REFERRAL FORM**
**Fax to: 717-504-8966**

Healthy Communities Partnership℠
Greater Franklin County

Today's Date _____

Fax referral to Healthy Communities Partnership and the PA FREE Quitline is for patients who are ***ready to quit in the next 30 days AND ready to accept a call from HCP and/or Quitline.*** If neither of these conditions are met, provide patient with Ouitline or other tobacco cessation resource information.

## PROVIDER(S): Complete this section. (Please PRINT clearly)

Provider Name _____ Contact Name _____

Clinic/Hosp/Dept _____ E-mail _____

Address _____ Phone _____

City/State/Zip _____ Fax _____

Please Check ☐ Patient agrees with provider to be referred to HCP and/or the PA FREE Quitline.

HCP and the Quitline are entities that are compliant with the Health Insurance Portability and Accountability Act (HIPAA). HCP and the Quitline will only be able to share service outcome information with you 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.

Please indicate whether you are a HIPAA covered entity: I am a HIPAA Covered Entity ☐ Yes ☐ No

☐ In the absence of the patient being physically present to provide signature, provider please check to indicate that **patient provided verbal consent** to be referred to HCP and/or the PA FREE Quiltine.

## PATIENT: Complete this section. (Please PRINT clearly)

_____
***Initials***

Yes, I am ready to quit and ask that a Quitline coach call me. I understand that the PA FREE Quitline will inform my provider about my participation. I also give permission to the PA FREE Quitline to share my information with the Pennsylvania Department of Health. This information will be kept private and confidential by the Pennsylvania Department of Health.

Best times to call? (Please check all that apply.) ☐ Morning (8-12) ☐ Afternoon (12-5) ☐ Evening (5-9) ☐ Anytime

☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Weekend ☐ Any day

[Caller ID will display 717-264-1470 (Healthy Communities Partnership).]

May we leave a message? ☐ Yes ☐ No

Are you hearing impaired and need assistance? ☐ Yes ☐ No

Date of Birth ____/____/____ Gender ☐ M ☐ F

Patient Name (Last) _____ (First) _____

Address _____ City _____ State _____

Zip Code _____ E-mail _____

Phone #1 (____) ____ – _____ Phone #2 (____) ____ – _____

Language ☐ English ☐ Spanish ☐ Other: _____

Patient Signature _____ Date ____/____/____

***PROVIDER PLEASE FAX COMPLETED FORM TO: 717-504-8966***

Or mail to: Healthy Communities Partnership, 232 Lincoln Way East, Suite B; Chambersburg, PA 17201

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

***in partnership with***

pennsylvania DEPARTMENT OF HEALTH

AMERICAN LUNG ASSOCIATION. IN PENNSYLVANIA

***Revised 1/24/2014***