

Illinois Tobacco Quitline

Tobacco Treatment Enrollment Form

PATIENT INFORMATION – Please Print

FIRST NAME		LAST NAME		
MAILING ADDRESS		CITY/ COUNTY	STATE	ZIP
EMAIL ADDRESS		DATE OF BIRTH	PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICAID/SCHIP <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:

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.

_____ SIGNATURE OF THE PATIENT OR PATIENT'S REPRESENTATIVE	_____ DATE
_____ PRINTED NAME OF PATIENT REPRESENTATIVE	_____ RELATIONSHIP TO PATIENT

TOBACCO TREATMENT CHECKLIST

Healthcare Professional to Complete the Following:

<i>ASSESSMENT</i> 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 _____
<i>ASSISTANCE</i> 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