



1.800.QUIT.NOW
(1-800-784-8669)

COLORADO QUITLINE FAX FORM

FAX TO: **800-261-6259**

For the latest version and more information, visit
cohealthproviders.org

DATE: _____

PATIENT INFORMATION (Print clearly)

Patient name: (Last) _____ (First) _____ Date of birth: _____
Gender: M F

_____ I am ready to quit tobacco and request that the Colorado QuitLine contact me to help with my quit plans. I understand that the Colorado
Initial QuitLine will inform my provider about my participation and quitting results.

Patient signature Date
This release shall be valid for one year after the above date.

Address: _____ City: _____ CO Zip: _____

Phone #1: _____ #2: _____ E-mail: _____

Best times to call: Morning Afternoon Weekend Evening **May we leave a message?** Yes No
Language: English Spanish Other _____ **Are you hearing impaired and need assistance?** Yes No

PROVIDER INFORMATION (Print clearly)

Provider name: _____ Clinic/Hosp/Dept: _____

Contact name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ E-mail: _____

Provider consent is required to provide nicotine replacement therapy (NRT) to individuals who have certain medical conditions or are pregnant. Please sign here if patient may use NRT.

Provider signature

Comments: _____

PLEASE COMPLETE FORM AND FAX OR MAIL TO:

FAX: **1-800-261-6259**

MAIL: **Colorado QuitLine
National Jewish Health
1400 Jackson St., M305
Denver, CO 80206**

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