



1-800-QUIT-NOW



Fax Number: 1-800-483-3114

Patient File Number: _____

CEASE (Clinical Effort Against Secondhand Smoke Exposure)

Provider Information:

Fax Sent Date: ____/____/____

Clinic Name: _____

Health Care Provider: _____

Contact Name: _____

I am a HIPAA-Covered Entity (Please check one) Yes No I Don't Know

Fax: (____) ____ - ____ Phone (____) ____ - ____

Comments:

Client/Patient Information: Gender: ____ male / ____ female Pregnant? ____ Y ____ N

If client is not the patient, please check: ____ Mother of patient / ____ Father of patient / ____ Other - _____

Client/Patient Name: _____ DOB: ____/____/____

Address: _____ City: _____ Zip: _____

Hm #: (____) ____ - ____ Wk #: (____) ____ - ____ Cell #: (____) ____ - ____

Language Preference (check one): English Spanish Other - _____

Tobacco Type (check primary use): Cigarettes Smokeless Tobacco Cigar Pipe

____ I am ready to quit tobacco and request the North Carolina Tobacco Use Quitline contact me (Initial) to help me with my quit plan.

____ I **DO NOT** give my permission to the North Carolina Tobacco Use Quitline to leave a message (Initial) when contacting me.

Patient Signature: _____ Date: ____/____/____

The North Carolina Tobacco Use Quitline will call you. Please check the **BEST 3-hour time frame** for them to reach you. **NOTE: The Quitline is open 7 days a week; call attempts over a weekend may be made at times other than during this 3-hour time frame.**

8am - 12am EST 12am - 3pm EST 6pm - 9pm EST 9pm - 12pm EST

Within this 3-hour time frame, please contact me at (check one): hm / wk / cell