



FAX REFERRAL FORM

Fax Number: (800) 483-3114

Patient stamp or label

Provider Information (Please print):

Fax Sent Date: ____/____/____

Clinic Name: _____ **Health Professional Name:** _____

I am a HIPAA-Covered Entity (Please check one) Yes No Unknown

Fax: (____) _____ - _____ **Phone** (____) _____ - _____

Client Information:

Client Name: _____ **DOB:** ____/____/____

Address: _____ **City:** _____ **Zip:** _____

Primary #: (____) _____ - _____ **Type:** HM WK CELL OTHER

Secondary #: (____) _____ - _____ **Type:** HM WK CELL OTHER

Language Preference (check one): English Spanish Other _____

____ I am ready to quit tobacco and request the Oklahoma Helpline contact me to help me with my quit plan.
(Initial)

____ I give my permission to the Oklahoma Helpline to leave a message when contacting me.
(Initial)

Client Signature: _____ **Date:** ____/____/____

Please check the BEST time frame for them to reach you. NOTE: The Helpline is open 7 days a week; call attempts over a weekend may be made at times other than the chosen time frame.

- Early Morning (7am – 9am) Morning (9am - 12pm) Early Afternoon (12pm - 3pm)
- Late Afternoon (3pm - 6pm) Evening (6pm - 9pm)

Within this 3-hour time frame, please contact me at (check one): Primary Secondary

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