



Freedom is within reach.

**Florida Quit for Life Line
REFERRAL FORM**

PROVIDER

Complete all of the following:

- Advised no tobacco in pregnancy and postpartum
 Assessed that patient wants to quit in the next 30 days
 Obtained permission to refer to the Quit for Life Line

Patient Name _____ Date _____

Referring Provider _____

Practice Name _____

Practice Address _____ Zip Code _____

Telephone _____ Fax _____

PATIENT

Assistance from the Quit for Life Line will increase your chances for success in quitting tobacco. The Life Line provides:

- Friendly, respectful support
- Expertise in tobacco and nicotine
- No-pressure, helpful counseling
- Ways to boost your confidence

Best day and time for Quit Line staff to call me:

Day _____ Time _____

My signature gives permission for my provider to FAX this form to the Florida Quit for Life Line. I understand that a Quit Line specialist will call me within the next week.

Patient Signature _____

Patient Telephone _____ Zip Code _____

FAX THIS FORM TO (877) 747-9528
 Questions? Call the Florida Quit for Life Line, 1-(877) U CAN NOW