Graphical user interface

Description automatically generatedTobacco Free Florida Health Care Provider

Referral Form

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Provider Information \***Required *Provider fills out. See examples on back.* | | | | | | | | | | | | | | | | | | | | |
| **Facility type:** | |  | | | | | | | | | | | | | | | | | | |
| Facility name\* | | | |  | | | | | | Department | | | |  | | | | | | |
| Facility NPI  (National Provider Identifier) | | | | |  | | | | | Referring provider | | | |  | | | | | | |
| Provider NPI  (National Provider Identifier) | | | | |  | | | | | Main contact person | | | |  | | | | | | |
| Address\* |  | | | | | | | | | City\* |  | | | | | | State\* | | |  |
| Zip code\* |  | | | County | |  | | | | Fax |  | | | | | | | | | |
| Email |  | | | | | | | | | Phone number\* | | |  | | | | | | | |
| I certify that I am a HIPAA covered entity | | | | | | | | | | Would you like an Outcome Report? | | | | | | | | | | |
| **Use this section to pre-authorize NRT** | | | | | | | | | | | | | | | | | | | | |
| *Note: While Tobacco Free Florida offers free quit medications to patients, using this form does not guarantee that they will get free quit medications.* | | | | | | | | | | | | | | | | | | | | |
| Please check the box to Pre-Authorize NRT: | | | I authorize the use of any modality of NRT for which my patient has coverage at dosage consistent with FDA Approved package labeling. | | | | | | | | | | | | | | | | | |
| Provider’s Name (Print) | | | | |  | | | | Provider’s Signature | | | | | |  | | | | | |
| **Patient Information \***Required *Patient fills out.* | | | | | | | | | | | | | | | | | | | | |
| First name\* |  | | | | | | Middle name | | |  | | | Last name\* | | | | | |  | |
| Address\* |  | | | | | | | | | | | | City\* | | | | | |  | |
| State\* |  | | | | | | Zip code\* | | |  | | | County\* | | | | | |  | |
| Best phone number\* |  | | | | | | Email |  | | | | | Date of birth\* | | | | | |  | |
| The best time to call you: *(check one)* | | | | | | | | Morning: 8am-Noon | | | | | | | | Evening: 5pm-9pm | | | | |
| Afternoon: Noon-5pm | | | | | | | | Anytime | | | | |
| Can we leave a voicemail? | | | | | | | |  | | | | | | | | | | | | |
| May we send text messages to this number? | | | | | | | |  | | | | | | | | | | | | |
| Language preference: | | | | | | | | English  Spanish  Other | | | | | | | | | | | | |
| Patient Signature\* | | |  | | | | | | | | | | | | | | Date\* |  | | |
| **Program Choice: check ONE box below** (see program descriptions on back). The provider will then submit this form via fax or email to the program listed below. | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | **Fax:** 1-888-975-1534 | **Email:** tobacco@ahec.ufl.edu | | | | | | | | |
|  | | | | | | | | | | | | **Fax:** 1-800-483-3114 | | | | | | | | |
|  | | | | | | | | | | | | **Fax:** 1-800-483-3114 | | | | | | | | |

Version 20, Revised August 2024

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to Tobacco Free Florida

**Referral Form Submission Instructions**

1. Provider Information: The provider completes this section. Examples are listed below:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Example 1** | | | | |
| **Facility type:** |  | | | |
| Facility name | | UF Health-Shands Hospital | Department | Internal medicine |
| Facility NPI  (National Provider Identifier) | | 2526272829 | Referring provider | John Doe |
| NPI  (National Provider Identifier) | | 3031323435 | Main contact person | Jane Doe |
| **Example 2** | | | | |
| **Facility type:** |  | | | |
| Facility name | | Walgreens | Department | #1234 |
| Facility NPI  (National Provider Identifier) | | 1516171819 | Referring provider | Jane Smith |
| NPI  (National Provider Identifier) | | 2021222324 | Main contact person | John Smith |

1. Patient Information: The patient provides their contact information.

*Program Choice*: Patient should select ONE program from the list.

* Provider should fax or email completed forms to the program the patient has selected.
* If the referral is sent to the in-person group or virtual Group Quit classes, the patient will be called by the Florida Area Health Education Center (AHEC) that serves the patient’s county to schedule them in a course.
* If the referral is sent to the Phone Quit or Web Quit program, a tobacco Quit Coach will call the patient to enroll them in their preferred program.

|  |  |  |
| --- | --- | --- |
| **Tobacco Free Florida Program Options** | | |
| **Group Quit** | **Phone Quit** | **Web Quit** |
| Register for a session with trained facilitators along with others who want to quit like you.   * Led by a trained specialist * Free 2-to-4-week supply of NRT (patches, gum, or lozenges) * Convenient times and locations * Group support in person or virtual | Personal support, tools and services via phone, plus access to an online dashboard to improve quit outcomes.   * 3 one-on-one sessions with a coach via phone, text, or chat * Unlimited inbound support via phone, text, or chat * Automated texting support * Online access to a dashboard * Free 4-week combo of NRT (patches, gum, or lozenges)   1-877-U-CAN-NOW (1-877-822-6669) | Live coach support via text or chat, plus access to an online dashboard   * Live coach support via text or chat * Automated texting support * Online access to a dashboard * Free 4-week combo of NRT (patches, gum, or lozenges) |

***Need more information about the programs available? Visit:*** [www.TobaccoFreeFlorida.com/QuitYourWay](http://www.TobaccoFreeFlorida.com/QuitYourWay)