ILLINOIS TOBACCO QUITLINE
ILLINOIS DEPARTMENT OF PUBLIC HEALTH
AMERICAN LUNG ASSOCIATION OF ILLINOIS
Where Quitters Always Win!

1-866-QUIT-YES

Tobacco Treatment Enrollment Form

PATIENT INFORMATION – Please Print

FIRST NAME	**LAST NAME**		
MAILING ADDRESS	**CITY/ COUNTY**	**STATE**	**ZIP**
EMAIL ADDRESS	**DATE of BIRTH**	**PREGNANT** ☐ YES ☐ NO	**MEDICAID/SCHIP** ☐ YES ☐ NO
PHONE NUMBER (Area Code) + Number ( )	**ALTERNATE PHONE NUMBER** ( )		

MAY WE LEAVE A MESSAGE? ☐ YES ☐ NO	**LANGUAGE PREFERENCE (Circle One)** ENGLISH SPANISH OTHER (SPECIFY): _____

THE QUITLINE USUALLY CALLS THE PATIENT BACK WITHIN ONE BUSINESS DAY OF RECEIVING A REFERRAL. WHEN SHOULD WE CALL?

Circle One: **7 am – 10 am** **10 am – 1 pm** **1 pm – 4 pm** **4 pm – 7 pm**

Patient to sign below / El paciente firma a continuación:

I hereby authorize my provider to release the information on this enrollment form to the Illinois Tobacco Quitline for purposes of my participation in the smoking cessation program. I also authorize the Illinois Tobacco Quitline and its representatives to contact me at the phone number(s) I have listed above upon receiving this referral from my provider.

Yo por este medio autorizo a mi proveedor que revele la información en este formulario de inscripción a la Línea para Dejar de Fumar en Illinois para participar en el programa para dejar de fumar. Yo también autorizo a la Línea para Dejar de Fumar en Illinois y sus representantes que se comuniquen conmigo al número de teléfono(s) que he provisto arriba, al recibir esta referencia de mi proveedor.

SIGNATURE OF THE PATIENT OR PATIENT'S REPRESENTATIVE FIRMA DEL PACIENTE O REPRESENTANTE DEL PACIENTE	DATE FECHA
PRINTED NAME OF PATIENT REPRESENTATIVE NOMBRE DEL REPRESENTANTE DEL PACIENTE EN LETRA DE MOLDE	RELATIONSHIP TO PATIENT PARENTESCO CON EL PACIENTE

TOBACCO TREATMENT CHECKLIST

Healthcare Professional to Complete the Following:

ASSESSMENT of readiness to quit:	☐ Ready to quit ☐ Thinking about quitting ☐ Not ready to quit Current level of tobacco use _____
ASSISTANCE to quit:	Would medication be appropriate? ☐ Yes ☐ No If yes, needs prescription for Zyban. Would Nicotine Replacement be appropriate? ☐ Yes ☐ No

CLINIC NAME: Signature of Clinic Personnel:	PHONE NUMBER: FAX NUMBER:

FAX THIS FORM TO: 217-787-5916