1-800-QUIT-NOW
SC Tobacco Quitline

SOUTH CAROLINA TOBACCO QUITLINE FAX REFERRAL FORM

Fax Number: 1-800-483-3114

FAX SENT DATE: ________/________/________

Provider Information:

PATIENT FILE NUMBER: _________________________

NAME OF CLINIC/PRACTICE/HEALTH SYSTEM

CLINIC ZIP CODE

NAME OF REFERRING PROVIDER

PROVIDER SPECIALTY ***(Select the CATEGORY that best describes this patient referral or select OTHER and specify it in the next field.)***

PROVIDER NPI #

OTHER CONTACT NAME ***(If applicable)***

FAX NUMBER ***(Include Area Code)***

PHONE NUMBER ***(Include Area Code)***

I AM A HIPAA COVERED ENTITY ***(Please check one)*** **YES** ☐ **NO** ☐ **DON'T KNOW** ☐

Patient Information:

PATIENT NAME ***(First Name, Last Name)***

DATE OF BIRTH ***(xx/xx/xxxx)***

MALE ☐ **FEMALE** ☐

1ST PHONE NUMBER ***(Include Area Code)*** **HM** ☐ **WK** ☐ **CELL** ☐

2ND PHONE NUMBER ***(Include Area Code)*** **HM** ☐ **WK** ☐ **CELL** ☐

LANGUAGE PREFERENCE ***(Please check one)*** **ENGLISH** ☐ **SPANISH** ☐ **OTHER**

______ **I agree to receive a call from the SC Tobacco Quitline and I understand that this is a TELEPHONE APPOINTMENT.**
(Initial)

______ **DO NOT LEAVE A MESSAGE ON MY PHONE.**
(Initial) ***** By not initialing, you are giving your permission for the quitline to leave a message.***

WHAT IS THE BEST TIME FOR THE QUITLINE TO CALL 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.

☐ **6AM – 9AM** ☐ **9AM – 12N** ☐ **12N – 3PM** ☐ **3PM – 6PM** ☐ **6PM – 9PM** ☐ **9PM – 12M**

Quitline Caller I.D. May Display this on Your Phone: 1-800-QUIT-NOW

PATIENT SIGNATURE: ____ **DATE:** _____/______/______

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Instructions for Completing the
South Carolina Tobacco Quitline Fax Referral Form
DHEC 1617 (10/2014)

DHEC Form 1617 is used by all "non-DHEC" health care providers to refer a patient who smokes or uses other tobacco products to the South Carolina Tobacco Quitline via a fax referral system. The following steps must be followed *prior* to sending a fax referral to the Quitline.

General:

1. Best Clinical Practices suggest following a brief 2As+R protocol to improve your patients' chances of quitting. Before referring a patient to the Quitline: **Ask** about tobacco use and document; **Advise** to quit and ask if patient is ready; **Refer** to Quitline for cessation counseling and support. Prepare patients for quitting with medication unless contraindicated or they may be eligible for free Nicotine Replacement Therapy once they register with the Quitline.

2. Enter **Patient File Number** and **Date of Fax Referral** at top of form.

Provider Information:

3. Enter name of your **Clinic, Practice or Health System**.
4. Enter your **Zip Code**.
5. Enter name of **Referring Provider**.
6. Enter your area of **Medical Specialty** in the drop-down box. Check the ONE CATEGORY that best describes this patient referral (Anesthesiology, BCN-*Best Chance Network*, Behavioral Health/ATOD, Cardiology, Family Medicine, Gastroenterology, Internal Medicine, Oncology, Oral/Dental Health, Orthopaedics, Pediatric Medicine, Prenatal/OB-GYN, Psychiatry/Mental Health, Pulmonology, Rheumatology, Social Work, Surgical Practice, WISEWOMAN or Other-*please specify*).
7. Enter your **National Provider Identifier or NPI** 10-digit identification number.
8. Enter another **Contact Name** for your practice, if applicable.
9. Enter your **Fax Number**, including area code.
10. Enter your **Phone Number**, including area code.
11. Check the box which describes your status as a **HIPAA Entity**.

Patient Information:

12. Enter **Patient's Name** (*first name, last name*).
13. Enter **Patient's Date of Birth** (*Month/Date/Year*).
14. Check **Gender of Patient**.
15. Enter **Patient's Primary (1st) and Secondary (2nd) Telephone Numbers**, including area codes and check if the number is for their **Home, Work or Cell** phone.
16. Check **Patient's Language Preference**.
17. **PATIENT MUST AGREE TO RECEIVE A CALL FROM THE QUITLINE.** If so, patient *must* write his/her initials on the line prior to the statement: "I agree to receive a call from the SC Tobacco Quitline and I understand this is a TELEPHONE APPOINTMENT." ***Patient must understand that the Quitline will call him or her at the time they have designated***.
18. If patient DOES NOT want the Quitline to leave a message on their telephone, patient *must* write his/her initials on the line prior to the statement: "Do not leave a message on my phone."
19. **PATIENT MUST CHECK THE BOX OF THE BEST 3-HOUR TIME FRAME FOR A QUITLINE REPRESENTATIVE TO REACH HIM OR HER BY PHONE.**
20. **PATIENT MUST SIGN AND DATE THE FORM.**
21. **PATIENT MUST BE GIVEN A COPY OF THE SIGNED FORM.**

Final Steps:

For patients with Caller I.D., the following may display on their phone: 1-800-QUIT-NOW.