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

# Tobacco Treatment Enrollment Form

## 1-866-QUIT-YES
1 - 8 6 6 - 7 8 4 - 8 9 3 7

**TTY for Hearing Impaired 1-800-501-1068**

## PATIENT INFORMATION – Please Print

| | | | |
|---|---|---|---|
| **FIRST NAME** | **LAST NAME** | | |
| **MAILING ADDRESS** | **CITY/ COUNTY** | **STATE** | **ZIP** |
| **EMAIL ADDRESS**<br>**GENDER** ☐ FEMALE ☐ MALE | **DATE of BIRTH** | **PREGNANT**<br>☐ YES ☐ NO | **HFS PARTICIPANT**<br>☐ YES ☐ NO |
| **PHONE NUMBER** (Area Code) + Number<br>( ) | **ALTERNATE PHONE** (Cell, Work Etc.)<br>( ) | | **RACE/ETHNICITY** |
| **MAY WE LEAVE A MESSAGE?**<br>☐ YES ☐ NO | **LANGUAGE PREFERENCE (Circle One)**<br>ENGLISH SPANISH OTHER (SPECIFY): _____ | | |

## WHEN SHOULD WE CALL?

**Please Circle One:** **7 am – 10 am** **10 am – 1 pm** **1 pm – 4 pm** **4 pm – 7 pm** **7 pm – 9 pm** **9pm – 11 pm**

**THE QUITLINE USUALLY CALLS THE PATIENT BACK WITHIN ONE BUSINESS DAY OF RECEIVING A REFERRAL.**

## PATIENT SIGNATURE

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 tobacco 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. I give the Quitline and the referring agency permission to discuss my use of service.

| | |
|---|---|
| **X** _____<br>SIGNATURE OF THE PATIENT OR PATIENT'S REPRESENTATIVE | _____<br>DATE |
| **X** _____<br>PRINTED NAME OF PATIENT REPRESENTATIVE | _____<br>RELATIONSHIP TO PATIENT |

## HEALTHCARE PROFESSIONAL TOBACCO TREATMENT CHECKLIST

| **1. ASK** *about use* | **2. ADVISE** *to quit* | **3. ASSESS** *readiness to quit* | **4. ASSIST** *in quit attempt* | **5. ARRANGE** *follow up* |
|---|---|---|---|---|
| Identify and document patient's tobacco use. | In a clear, strong personalized manner, urge patient to quit. | Is patient willing to make an attempt? | Suggest counseling or pharmacotherapy to assist in quit. | By faxing this form, the Illinois Tobacco Quitline will follow-up. |

| | |
|---|---|
| *ASSESSMENT* of readiness to quit: | ☐ Ready to quit<br>☐ Thinking about quitting Current level of tobacco use _____<br>☐ Not ready to quit |
| *ASSISTANCE* to quit: | Is Chantix appropriate? ☐ Yes ☐ No *(If yes, please provide patient with prescription)*<br>Is Bupropion appropriate? ☐ Yes ☐ No *(If yes, please provide patient with prescription)*<br>Is Nicotine Replacement appropriate? ☐ Yes ☐ No *(If Medicaid, please provide patient with prescription)* |
| ADDITIONAL COMMENTS: | |

**CLINIC NAME:**

**PHONE:**

**FAX:**

print or stamp here

**SIGNATURE of Clinic Personnel:**

**X**_____

FAX THIS FORM TO: 217-787-5916