

Referring facility and healthcare provider information:

□ Clinic □ Pharmacy □ Hospital □ Other		□ I certify that I am HIPAA covered entity				
Facility name		Department				
Fax number	Phone number		Facility NPI (National Provider Identifier)			
Address		Zip	County			
Referring health care professional						
Email		National Provider Identifier (NPI) Number				
Would you like an Outcome Report on whether the patient enrolled, declined or was unreachable?						
(Please select your preferred method)						
□ I want emailed outcome reports □ I want faxed outcome reports □ I do not want outcome reports						
Use this section to pre-authorize NRT						
*Note: As patients have different benefits, using this form does not guarantee they will get free quit medications.						
Please check the box I authorize 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				

Referral contact information

You agree that we may contact you at the phone number you give us. Note that calls may be automated. Some messages may be pre-recorded.

First name		Middle name		Last name	
State	Zip code	Phone number		Date of birth	
Language preference	│ □ English □ Other				
May we send text messages to this number?					
Patient signature box				Date	
Best contact times: When are good weekday times to call?			When are good weekend times to call?		
Dest contact times.	□ Mornings (8 a.m12 p.m.)		□ Mornings (8 a.m12 p.m.)		
	□ Afternoons (12 p.m4 p.m.)		□ Afternoons (12 p.m4 p.m.)		
	Evenings (4 p.m8 p.m.)		🗆 Evenings (4 p.m8 p.m.)		

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