

**PLEASE
PRINT
CLEARLY**



Somerset
MEDICAL CENTER
110 Rehill Avenue
Somerville, NJ 08876-2598

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Phone: 908-685-2442 Fax: 908-685-2548

FAX-TO-QUIT REFERRAL FORM

- STEP 1:** Provider fills out top portion of referral form
- STEP 2:** Patient fills out contact information and signs form
- STEP 3:** Provider makes copy for patient
- STEP 4:** Provider faxes form to the Tobacco Quitcenter at **908-685-2548**

Provider

1. Patient's Name: _____ DOB: __/__/__

2. Referring Provider/Facility: _____ Provider Phone # _____

3. List Medical Diagnoses and/or prescription drugs affected by smoking: *

4. List other symptoms related to smoking (e.g., cough, shortness of breath): *

*Please complete this information, which is necessary for insurance reimbursement.

Physician Signature: _____ Date: _____

Patient

Patient Signature: _____

Today's Date: _____

The Tobacco Quitcenter will call you.

Phone # (____) _____ - _____

Alternate Phone # (____) _____ - _____

Please check the best times for the Clinic to reach you.

Morning Afternoon Evening

If you are unavailable when we call you, may we leave a message, identifying ourselves as the Tobacco Quit Center

Yes No

Please write any additional information here (e.g. your address etc):
