



QUITLINE REFERRAL PROGRAM

Step 1. **The Referral**

Faxable Form and Electronic Charting Options

Step 2. **Tools You Can Use**

Promotional Toolkit Items available

Step 3. **Measured Participation**

Quarterly Usage Reports available

Benefits

- ✓ Direct referral into program and local resources
- ✓ Co-branding and Electronic Charting options negotiable
- ✓ Materials are Free
*in limited quantities
- ✓ English & Spanish
- ✓ Satisfy JCAHO with Reports

QUITLINE COMMUNICATION NETWORK

The Quitline Communication Network (QCN) is a cooperative group of organizations, agencies and businesses committed to serving the smoking cessation needs of Illinois in part by working together to identify and or create opportunities which will maximize usage of the state's free tobacco quitline.

Contact Information: info@lungil.org or 1800-LUNG-USA (option 1)



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
EMAIL ADDRESS		DATE of BIRTH	PREGNANT	HFS PARTICIPANT
			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
PHONE NUMBER (Area Code) + Number ()	ALTERNATE PHONE (Cell, Work Etc.) ()		RACE/ETHNICITY	
MAY WE LEAVE A MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	PREFERENCE ENGLISH SPANISH OTHER (SPECIFY):			

WHEN SHOULD WE CALL? 7 am – 10 am 10 am – 1 pm 1 pm – 4 pm 4 pm – 7 pm 7 pm – 9 pm
(Please Circle One)

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

PATIENT SIGNATURE – 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 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.

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. Doy el Quitline y el permiso de la agencia que se refiere de discutir mi uso del servicio

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

HEALTHCARE PROFESSIONAL TOBACCO TREATMENT CHECKLIST

1. ASK <i>about use</i> Identify and document patient's tobacco use.	2. ADVISE <i>to quit</i> In a clear, strong personalized manner, urge patient to quit.	3. ASSESS <i>readiness to quit</i> Is patient willing to make an attempt?	4. ASSIST <i>in quit attempt</i> Suggest counseling or pharmacotherapy to assist in quit.	5. ARRANGE <i>follow up</i> By faxing this form, the Illinois Tobacco Quitline will follow-up.
ASSESSMENT of readiness to quit:		<input type="checkbox"/> Ready to quit <input type="checkbox"/> Thinking about quitting <input type="checkbox"/> Not ready to quit		
ASSISTANCE to quit:		Is Chantix appropriate? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please provide patient with prescription) Is Bupropion appropriate? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please provide patient with prescription) Is Nicotine Replacement appropriate? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Medicaid, please provide patient with prescription)		
ADDITIONAL COMMENTS:				

In collaboration with:

YOUR LOGO HERE

(contact info@lungil.org)

Clinician Signature X _____

Printed Name: _____

Phone or Email: _____

FAX FORM TO: 217-787-5916

ILLINOIS TOBACCO QUITLINE

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
AMERICAN LUNG ASSOCIATION OF ILLINOIS

Where Quitters Always Win!
1-866 Quit-Yes / 1-866-784-8937

QUITLINE REFERRAL PROGRAM


TEAR OFF PAD and COASTER
(both have same 2-sided design)



5 - Tear off Pad (75 sheets per pad)
 10- Tear off Pad (75 sheets per pad)

125 - individual Coasters
 250 - individual Coasters

BROCHURE



25 - English language
 50 - English language

25 - Spanish language
 50 - Spanish language

WINDOW CLING – New Item!

1 - campus 2 - campus
 1 - 15 feet 2 - 15 feet



POSTER

1 - size 8 x 11
 2 - size 8 x 11



CAR WINDOW DECAL – New!

1 - size 2 x 3
 2 - size 2 x 3



AXMINSTER

25 Individual Forms
50 Individual Forms



Name: _____

Company: _____

Address: _____

City/State: _____ Zip: _____

Phone: _____ Fax: _____

Fax this form to the Quitline at
217-787-5916
OR
mail this form to: American Lung Association of IL
3000 Kelly Lane, Springfield, IL 62711