State of Illinois
Illinois Department of Public Health

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
1-866-784-8937
TTY for Hearing Impaired 1-800-501-1068

PATIENT INFORMATION – Please Print

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

WHEN SHOULD WE CALL?

Please Circle One: 7 a.m. – 10 a.m. 10 a.m. – 1 p.m. 1 p.m. – 4 p.m. 4 p.m. – 7 p.m. 7 p.m. – 9 p.m. 9 p.m. – 11 p.m.

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 ______________________________ ______________
SIGNATURE OF THE PATIENT OR PATIENT'S REPRESENTATIVE DATE

X ______________________________ ______________
PRINTED NAME OF PATIENT REPRESENTATIVE 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 ☐ Thinking about quitting Current level of tobacco use ____________ ☐ Not ready to quit
ASSISTANCE to quit:	Is Chantix appropriate? ☐ Yes ☐ No *(If yes, please provide patient with prescription)* Is Bupropion appropriate? ☐ Yes ☐ No *(If yes, please provide patient with prescription)* Is Nicotine Replacement appropriate? ☐ Yes ☐ No *(If Medicaid, please provide patient with prescription)*
ADDITIONAL COMMENTS:	

CLINIC NAME: **PHONE:** print or stamp here **FAX:**	**SIGNATURE of Clinic Personnel:** X______________________

FAX THIS FORM TO: 217-787-5916

February 3, 2011