



ILLINOIS DEPARTMENT OF PUBLIC HEALTH  
AMERICAN LUNG ASSOCIATION OF ILLINOIS

Where Quitters Always Win!

1-866-QUIT-YES

TTY for Hearing Impaired 1-800-501-1068

# TOBACCO TREATMENT ENROLLMENT FORM

## PATIENT INFORMATION Please Print.

FIRST NAME		LAST NAME			
MAILING ADDRESS		CITY/ COUNTY		STATE	ZIP
EMAIL ADDRESS		DATE of BIRTH	PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO		MEDICAID/SCHIP <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		LANGUAGE PREFERENCE (Circle One) 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**

The quitline usually 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

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

## HEALTHCARE OR TOBACCO CESSATION PROFESSIONAL CHECKLIST

<b>1. ASK about use</b> Document patient's tobacco use below.	<b>2. ADVISE to quit</b>	<b>3. ASSESS readiness to quit</b> Is patient ready to make quit attempt?	<b>4. ASSIST in quit attempt</b> Addiction is mental, physical and cultural. Suggest counseling, and pharmacotherapy to assist in quit.	<b>5. ARRANGE follow up</b> Illinois Tobacco Quitline will complete follow-up.
<b>ASSESSMENT</b> of readiness to quit:	<input type="checkbox"/> Ready to quit <input type="checkbox"/> Thinking about quitting <input type="checkbox"/> Not ready to quit		Current level of tobacco use _____	
<b>ASSISTANCE</b> to quit:	Is Chantix appropriate? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, provide prescription) Is bupropion/Wellbutrin/Zyban appropriate? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, provide prescription) Is Nicotine Replacement appropriate? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Medicaid, provide prescription)			
ADDITIONAL COMMENTS:				



In collaboration with:

Signature of Referring Professional:

**X** \_\_\_\_\_  
FAX FORM TO: 217-787-5916