

# Georgia Tobacco Quit Line

## Instructions For Fax Back Form



If the patient/client wishes to quit using tobacco, and would like to be helped via telephone by the Georgia Tobacco Quit Line:

1. Participant fills out form, including signature, and the best time to be reached by the Georgia Quit Line
2. Clinics (or other agencies) Fax the **completed** form to the number listed on the form to:  
**(1-800-483-3114)**, which is Free and Clear Inc.
3. A Certified Tobacco Specialist with Free and Clear, Inc. will make three attempts to reach the participant within 48 hours of receiving the Fax Back Referral.
4. Free and Clear, Inc. will treat each fax referral as a standard intervention. If Free and Clear, Inc has not reached the participant after three attempts, they will mail the participant a “Quit Kit”, to the address information on the fax referral form.
4. The initiating agency will then receive a detailed report back form Free and Clear, Inc. This will include information whether the participant was reached or not after three attempts by Free and Clear staff.

# GEORGIA TOBACCO QUIT LINE FAX REFERRAL

## 1-800-483-3114

**Provider Information:**

Fax Sent Date: \_\_\_/\_\_\_/\_\_\_

Clinic Name: \_\_\_\_\_

Health Care Provider: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Fax: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Comments:

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**Patient Information:**

Gender: \_\_\_male/ \_\_\_female

Pregnant? \_\_\_Y \_\_\_N

Patient Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Address:

\_\_\_\_\_ City \_\_\_\_\_ Zip: \_\_\_\_\_

Primary#: (\_\_\_\_) \_\_\_\_\_ Type \_\_\_HM \_\_\_WK \_\_\_Cell

Secondary: (\_\_\_\_) \_\_\_\_\_ Type \_\_\_HM \_\_\_WK \_\_\_Cell

Language Preference (check one): \_\_\_English \_\_\_Spanish \_\_\_Other-\_\_\_\_\_

Tobacco Type (Check All that apply): \_\_\_Cigarettes \_\_\_Smokeless Tobacco \_\_\_Cigar \_\_\_Pipe

\_\_\_\_ I am ready to quit tobacco and request the **Georgia Tobacco Quit Line** contact me to help with my quit plan.  
(Initial)

\_\_\_\_ I agree to have the **Georgia Tobacco Quit Line** tell me my health care provider(s) that I enrolled in Quit Line  
(Initial) services and provide them with the results of my participation.

**Congratulations on having taken this important step! Telephone support from the Tobacco Treatment Specialist will greatly increase your chance of success.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

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**The Georgia Quit Line will call you to get you started on the road to becoming tobacco-free!  
Please circle The BEST 3-hour time frame for them to reach you!**

9am – 12pm

12pm -3pm

3pm – 6pm

6pm – 9pm ET

Within this 3-hour time frame, please contact me at (check one): \_\_\_Primary / \_\_\_Secondary

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**Confidentiality Notice:** This Facsimile contains confidential information. If you have received this facsimile in error, please notify the sender immediately by telephone and confidentially dispose of the material. Do not review, disclose, copy, and distribute it.