Maine Tobacco HelpLine
Referral Form

Date sent: ____/____/____

Please fax completed form to 662-5102.

Information About Clinician Making Referral

Practice/Hospital:_____

Clinician Making Referral:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

Information About Patient/Client Being Referred

Patient/Client:_____Date of Birth:_____/_____/_____

Street Address:_____

City:_____State:_____Zip:_____

Phone where you can be reached:_____ Will you need translation services? Yes ☐ No ☐

Male ☐ Female ☐ Deaf/TTY ☐ Language (specify):_____

If inpatient, please included estimated discharge date: _____/_____/_____

Please check the BEST time frame for the HelpLine to reach you, Monday-Friday.

8am-12pm ☐ 12pm-3pm ☐ 3pm-6pm ☐

If we don't reach you, we will leave a message with a call back number.
Check this box if you do not want a message left ☐

I authorize the Maine Tobacco HelpLine to contact me. (Sign below)

Patient/Client Signature:_____
(If patient/client unable to sign, person making referral may sign off to indicate verbal consent.)

Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services
Paul R. LePage, Governor — Richar Hamilton, Commissioner

1-800-207-1230
MAINE TOBACCO HELPLINE

Questions? Call the Maine Tobacco HelpLine at 1-800-207-1230