BABY & ME – Tobacco Free
FAX-TO-QUIT

Health Care Provider Referral Form

To: Washoe County Health District
FAX to: 775-328-3750
Or EMAIL to: hngo@washoecounty.us

PATIENT INFORMATION (PLEASE PRINT)

Patient Name:_____ Date of Birth: _____/_____/_____

Address: _____

Email Address: _____

Phone #: _____ Estimated Delivery Date: _____/_____/_____

I (undersigned) give permission for the support of staff and/or facilitator of the BABY & ME – Tobacco Free Program to contact me, enroll me in the program, assist me in quitting smoking, and give feedback regarding my progress to the health care provider listed below.

Patient Name (print):_____

_____ _____
Patient Signature **Date**

REFERRING PHYSICIAN INFORMATION

_____
Health Care Provider's Name

_____
Facility

_____ _____
Facility Address **City, State, Zip**

_____
Phone Number

Patient is approved to use over-the-counter Nicotine Replacement Therapy. ☐ YES ☐ NO

Contact Information: **Washoe County Health District**
1001 East Ninth Street, Building B
775-328-2480 or hngo@washoecounty.us