FAX REFERRAL FORM

Smoking Treatment Center

SPONSORED BY:
Imperial Health
Get Help Quit Smoking
SMOKING CESSATION TRUST

501 Dr. Michael DeBakey Dr., 4th floor • Lake Charles, LA 70601
Phone: (337) 312-8690 • Fax: (337) 312-8691 | info@smokingtreatmentcenter.com • www.smokingtreatmentcenter.com

Step 1. Patient Information

Today's Date: _____

Country of Residence: _____

First Name: _____ Last Name: _____ MI: _____

Home Phone: _____ Cell Phone: _____

Best Contact Time: ○ Morning ○ Afternoon ○ Evening

I understand that by signing or verbally agreeing to this form, a staff member of the Smoking Treatment Center will contact me to provide information about tobacco cessation treatment. My participation is voluntary, and if I wish, I will be scheduled for an appointment. Any information I provide will be kept confidential.

Signature: _____ or Verbal Authorization Given: ○ (check)

Step 2. Referring Healthcare Provider

First Name: _____ Last Name: _____ MI: _____

Institution Name: _____ City: _____ State: _____

Phone: _____

Step 3. Fax to the Smoking Treatment Center at (337) 312-8691