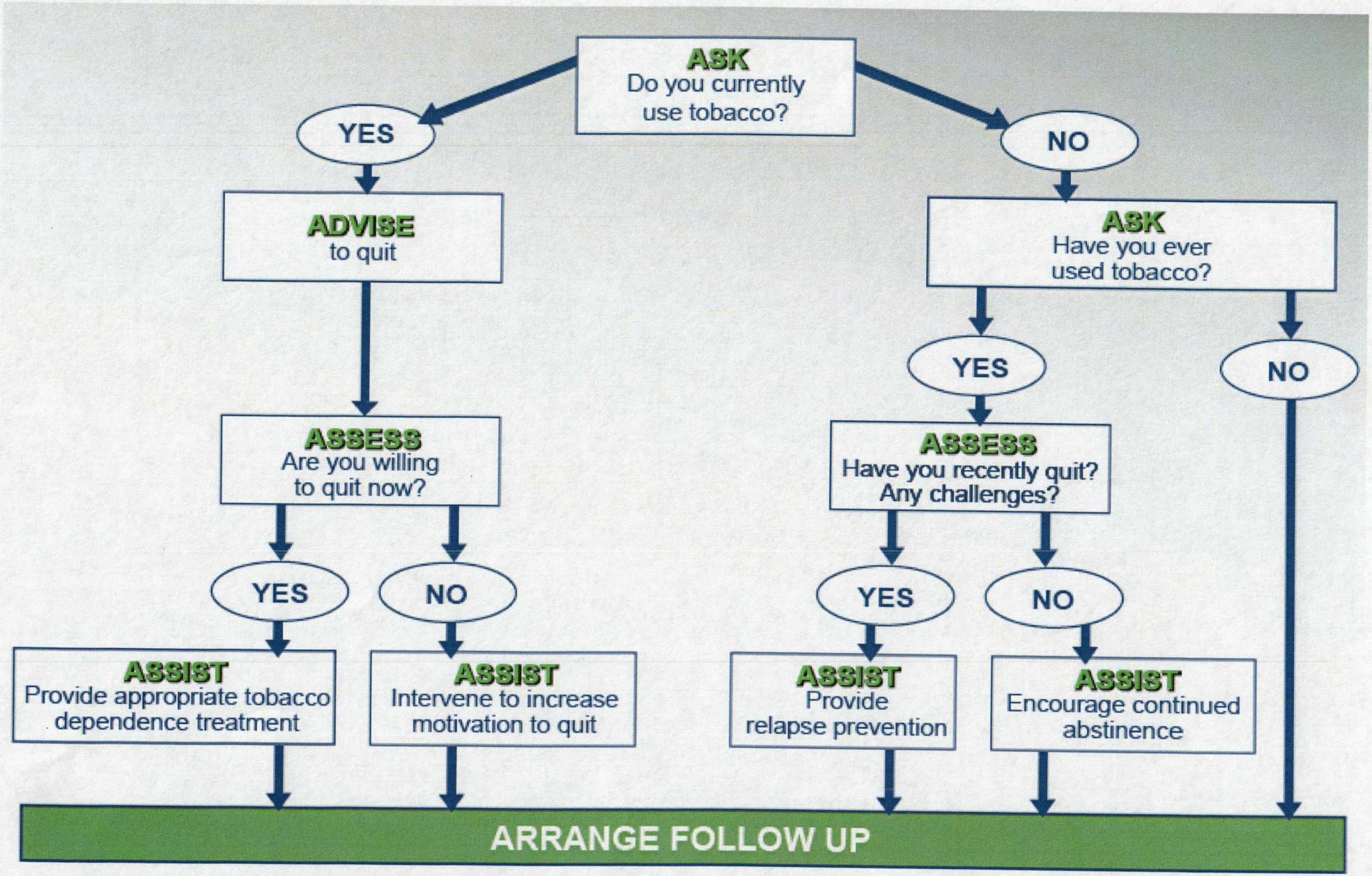
ASK
Do you currently use tobacco?
YES
NO
ADVISE
to quit
ASK
Have you ever used tobacco?
YES
NO
ASSESS
Are you willing to quit now?
ASSESS
Have you recently quit? Any challenges?
YES
NO
YES
NO
ASSIST
Provide appropriate tobacco dependence treatment
ASSIST
Intervene to increase motivation to quit
ASSIST
Provide relapse prevention
ASSIST
Encourage continued abstinence
ARRANGE FOLLOW UP

District Health Department #10
Healthy People, Healthy Communities

Tobacco Treatment Specialist Program Referral

Today's Date _____ **Fax to: 231-723-1477**

Patient Information:

I am recommending (Client name):_____
Enroll in the Tobacco Treatment program at District Health Department#10 based on use of:

☐ **Cigarettes** ☐ **Chew Tobacco** ☐ **E-cigarette**

Gender: ☐ Male ☐ Female **Language:** ☐ English ☐ Spanish

Best time to call: _____ May we leave a message? _____
Phone: (_____)_____

_____ *Initial* Yes I have consented to the Tobacco Treatment referral from my Care Provider. I consent to being contacted by a Tobacco Treatment Specialist from District Health Department#10. I understand that I do not need to commit with the first call. If I do, I understand the specialist will inform my provider about my participation.

Patient Signature: _____ Date:_____

Person making referral please complete:

Agency name: _____ Contact Name: _____
E-mail: _____ Phone: (_____)_____
Fax: (_____)_____

Signature: _____

PLEASE FAX TO: 1-231-723-1477
Or mail to: District Health Department #10 385 Third St., Manistee, MI 49660 **Attn: Holly Joseph**

For questions please contact: Holly Joseph
Email: hjoseph@dhd10.org **Phone: 231-316-8558**

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

5/2016 (KR)