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| **Primary Care Provider – Tobacco Cessation Referral**  **Fax to SPH Wellness Services at 447-2993** |  |  |

**St. Peter’s Health Tobacco Cessation Program Referral Instructions**

**Please include ALL information required below and visit our FAQ page at** [**www.sphealth.org/tobaccocessation**](http://www.sphealth.org/tobaccocessation) **for any further inquiries. For any questions, please call 447-2527 to speak with the program manager or email** [**sphfreenow@sphealth.org**](mailto:sphfreenow@sphealth.org)**. Once referral is received we will contact patient based on listed information at bottom.**

**Provider Instructions**

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| **St. Peter’s Health Tobacco Cessation Program uses an evidenced-based 7-week group counseling program from the American Lung Association called Freedom From Smoking® which supports and encourages use of both pharmacotherapy and counseling services to achieve the best quit results.**   * **Review with your patient if they are a candidate for pharmacotherapy and provide the Rx needed. Considering evidence-based research shows best results using both pharmacotherapy and counseling, we strongly encourage it.** * **If prescribing varenicline (Chantix ®), note the program includes a “Quit Date” during week 4, so it is preferred patient begin taking the medication no earlier than the first day of the program up to 1 week before the Quit Date. Please review with your patient.** * **Please mark the following if you prescribed any of the following 7 FDA-approved medications:**   **NRTs: \_\_\_\_\_ Patch \_\_\_\_\_ Gum \_\_\_\_\_Inhaler \_\_\_\_\_ Nasal Spray \_\_\_\_\_ Lozenge**  **Non-NRT medications: \_\_\_\_\_ bupropion SR (Zyban®) \_\_\_\_\_ varenicline (Chantix®)**   * **Scheduled a follow-up appointment: *(if no, please indicate you’d like a Wellness Services team member to ensure follow up appointment is scheduled after program starts and/or “Quit Date”)***   **\_\_\_\_\_ Yes, follow-up has been scheduled \_\_\_\_\_ No, follow up has not been scheduled**  **\_\_\_\_\_ Please contact my office when patient enters into Freedom From Smoking®   program so a follow-up can be scheduled** |  |

**PATIENT INFORMATION**

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| **\*Patient’s Last Name:** |  | **\*Patient’s First Name:** | |  | | **\*Gender:** | |  |
|  |  |  |  | |  | |  | |
| **\*Patient’s Phone #:** | ( ) - | **\*Patient’s DOB:** | / / | | **\*Date of Referral:** | | / / | |

**PROVIDER INFORMATION**

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| **\*Provider’s First and Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
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| **\*Provider’s Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **\*Provider’s Fax #:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |