

**BABY & ME – Tobacco Free FAX-TO-QUIT
Health Care Provider Referral Form
To: (Vanderburgh County Health Department)
FAX to: (812) 435-6342**



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:
(Mary Jo Borowiecki, Grant Administrator for Baby & Me)
(Vanderburgh County Health Department)
(420 Mulberry Street)
(812-435-5807)