



A Service of the Try-To-Stop Smokers' Helpline

In Collaboration with the Massachusetts Department of Public Health and Massachusetts Health Plans



SOUTHCOAST HOSPITALS GROUP

- CHARLTON
- ST. LUKE'S
- TOBEY
- HOMECARE

Patient Stamp, Label or Info (Name, Record Number/DOB, Date)

- If a patient is interested in quitting smoking, fill out this form with them.
- Fax completed form to 1-866-560-9113.
- The Try-To-Stop Smokers' Quitline will contact the patient, offer free cessation services and send feedback reports to the provider listed below.
- This program is free for all Massachusetts residents regardless of insurance status

Massachusetts Enrollment Form

Tobacco users can also call 1-800-Try-To-Stop (1-800-879-8678) to receive services

Patients: Complete this section

<hr/> First Name	<hr/> Last Name	Are you 18 or older?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<hr/> Mailing Address		<hr/> City	<hr/> State Zip
<hr/> ()			
<hr/> Phone Number			
When should we call? (check all that apply) <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> No preference			
Language Preference: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (specify) _____			
May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Primary Insurance of Tobacco User: <input type="checkbox"/> Blue Cross Blue Shield MA <input type="checkbox"/> Tufts Health Plan <input type="checkbox"/> Harvard Pilgrim			
<input type="checkbox"/> MassHealth/Medicaid <input type="checkbox"/> Other <input type="checkbox"/> None			
<p>I authorize this provider to release the information on this enrollment form to QuitWorks so that I may be contacted and participate in the QuitWorks program. I also authorize QuitWorks to disclose information about my progress in attempting to quit smoking to the health care provider listed on this form.</p>			
<hr/> Patient Signature			<hr/> Date

Health Care Providers: Complete this section

Referring Provider: Southcoast Hospitals Group	Phone Number (508) 679-7015	
Facility: Southcoast Hospitals	Fax Number (508) 679-7083	
Address: 363 Highland Avenue, Fall River, MA 02720		
Send feedback report to:		
<input checked="" type="checkbox"/> Same as above or () ()		
Name	Phone Number	Fax Number
PEDIATRICS ONLY:		
Patient's relationship to child: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other (specify) _____		
Child/Children's name: (to help with recordkeeping) _____		

Copies of this form can be downloaded from WWW.QUITWORKS.ORG

Fax this form toll-free to 1-866-560-9113

NICOTINE REPLACEMENT OPTIONS

PATCHES

Nicoderm [®] CQ 7 mg, 14 mg, 21 mg	Initial: 1 patch/24 hrs. MAX: Same as above	Treatment Duration: 8 wks.
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GUM

Nicorette [®] 2 mg, 4 mg	Initial: 1 piece every 1–2 hrs. MAX: 24 pieces/24 hrs.	Treatment Duration: 8–12
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NON-NICOTINE MEDICATION

BUPROPION HCL SR

Wellbutrin SR 150 mg tablets	Initial: 150 mg/day (days 1–3) 300 mg/day (day 4+) MAX: 300 mg/day	Treatment Duration: 7–12 wks.
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VARENICLINE

Chantix [®]	Initial: 0.5 mg/day (days 1–3) 0.5 mg/2x/day (days 4–7) 1.0 mg/2x/day (day 8+) MAX: 2 mg/day	Treatment Duration: Up to 12 wks.
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Inclusion of this adult dosage chart is strictly for the convenience of the prescribing provider. Please consult the Physicians' Desk Reference for complete product information and contraindications. This chart does not indicate or authorize insurance benefit coverage for any of these medications. For insurance benefit information, the patient will need to contact his/her insurer directly. The cost or provision of these medications is not included as any part of the Try-To-STOP TOBACCO Resource Center of Massachusetts or QuitWorks program.

Make smoking history.

I hereby authorize Southcoast Hospitals Group to make a one time disclosure of the information specified on this form to the Massachusetts Try-To-Stop Smokers' Helpline.

I understand that I may revoke this authorization at any time by requesting such from Southcoast in writing, unless it has been acted on already. This authorization will expire after the disclosure is made.

I may refuse to sign this authorization. My health care, payment for my health care, and my health care benefits will not be affected if I do not sign this form (except for the referral to the Try-To-Stop Tobacco Resource Center). I have the right to receive a copy of this authorization after I sign it.

I understand that the information disclosed pursuant to this authorization could be re-disclosed by the recipient and if so may not be subject to federal and state law protecting its confidentiality.

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accepted all of the terms in the authorization form and authorize the disclosure of my protected health information as described on this form.

Patient Signature

Date