Tobacco Cessation Referral

Please circle your preferred option:

1-800-Quit-Now My personal physician Tobacco Treatment Specialist

Patient Information:

Patient Name: _____

Employee ID: _____

Patient Relationship: Employee or Spouse

Address: _____

City: _____ Zip: _____

Date of Birth: _____

Gender: Male Female

Primary Phone Number: (_____) _____

Email address: _____

Language Preference: English Spanish Other

Contact Time Frame: Please select time frame below:

The Oklahoma Tobacco Helpline will call you. Please check the best 3-hour time frame for them you reach you. Note: The Helpline is open 7 days a week; call attempts over a weekend may be made at times other than during this 3-hour time frame. **Please circle best option for you below:**

(6AM - 9AM) (9AM - 12PM) (12PM - 3PM) (3PM - 6PM)

I DO give permission to the Oklahoma Tobacco Helpline to leave a message when contacting me. By signing below, I agree to submit my consent.

Signature: _____

Date: _____

Submit Form to Employee Wellness: Fax: 405.552.8729 *OR* Inter-office: 001.7063 *OR* Email: employeewellness@integrisok.com *OR* Mail: Employee Wellness, 5100 N Brookline Ave, Suite 175, OKC OK 73112