NORTH Dakota
Be Legendary.™

NDQUITS REFERRAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES
TOBACCO PREVENTION AND CONTROL
SFN 59499 (9-2022)

NDQuits

Please fax to NDQuits 1-855-997-8487 (1-855-99 QUITS)

REFERRING PROVIDER INFORMATION (print clearly) Feedback will only be sent to HIPAA-covered entities to either the fax number or the email listed below.				
Provider First Name		Provider Last Name		
Name of Health System/Facility				
Address		City	State	ZIP Code
Telephone Number	Fax Number	Email Address for HIPAA-Covered Entity		
Type of HIPAA-Covered Entity ☐ Health Care Provider ☐ Health Plan ☐ Not-Covered entity				

As a HIPAA-covered entity you are authorized to receive personal health information for the referred individual.
As a Not-covered entity, personal health information will not be shared back for the referred individual.

Provider consent is required to provide nicotine replacement therapy (NRT) to pregnant or breastfeeding individuals.
Is the patient: ☐ Pregnant ☐ Breastfeeding

(If Provider) I authorize NDQuits to send over-the-counter NRT. Sign here if patient may use NRT:

Provider Signature	Date

PATIENT INFORMATION (*required) (print clearly)		
*Patient First Name		*Patient Last Name
*Patient ZIP Code	*Date of Birth	*Phone ☐ Cell ☐ Home ☐ Work
*Do you require accommodation while participating in the program such as TTY or translator? ☐ Yes (specify): ☐ No		
*Language ☐ English ☐ Spanish ☐ Other (specify):		
***Consent to messages.** I consent to receive messages at the number provided. The voicemail may be a recording from an autodialer.		☐ Yes ☐ No
***Consent to Text.** I consent to receive text messages with motivational messages and other program events, such as appointment reminders, medication shipments, and quit anniversaries.		☐ Yes ☐ No

I, the patient (or authorized representative), give permission to release my information to NDQuits. The purpose of this release is to request an initial phone call to discuss my interest and participation in the tobacco treatment program and allow communication with the provider identified on this form. I may revoke this authorization at any time in writing, but if I do, it will have no effect on actions taken prior to receiving the revocation.

*Patient Signature	*Date

If filling out the form on behalf of the patient:

Authorized Representative Name (First)	Authorized Representative Name (Last)
Authorized Representative's Signature	Date

*Participant or Authorized Representative signature required to place a phone call to the patient.

FAX COMPLETED FORM TO: 1-855-997-8487

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