**Fax Referral Form**  
**Tobacco Treatment Services**

**Step 1. PATIENT**

Today’s Date: _____/_____/______  
County of Residence: __________________________

Patient’s Name: ___________________________________  
Last                  First                  MI

Telephone Number: (______) ___________  
Alternate Number: (______) ___________

Best Contact Time:  ☐ Morning  ☐ Afternoon  ☐ Evening

I understand that by signing or verbally agreeing to this form, a staff member from an ACT Center Tobacco Treatment Clinic will contact me to provide information about tobacco treatment. My participation is voluntary, and if I wish, I will be scheduled for an appointment. Any information I provide will be kept confidential.

Patient’s Signature: ______________________________ or  Verbal Authorization Given: ☐ (check)

**Step 2. REFERRING HEALTHCARE PROVIDER**

Name: __________________________________________
Last                  First                  MI

Institution: ______________________________________
Name                  City, State

Telephone Number: (______) ________________

**Step 3. Send Fax**

Jackson MS       University of MS Medical Center       Fax 601 815 5986       Tel 601 815 1180

*ACT Center is funded by the Mississippi State Legislature, University of Mississippi Medical Center, and Mississippi State Department of Health*