UMMC
ACT Center for Tobacco Treatment, Education and Research

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

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