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. Fax to the Preferred Site

City	Hospital	Fax Number	Phone Number
❑ **Batesville**	Panola County Medical Center	**662 712 1482**	662 712 1472
❑ **Brookhaven**	King's Daughters Medical Center	**601 835 9380**	601 835 9406
❑ **Greenville**	Delta Regional Medical Center	**662 725 3660**	662 725 2178
❑ **Gulfport**	Memorial Hospital	**228 867 4490**	228 867 4022
❑ **Iuka**	North MS Medical Center	**662 423 4082**	662 423 4675
❑ **Jackson**	University of MS Medical Center (main)	**601 815 5986**	601 815 1180
❑ **McComb**	SW MS Regional Medical Center	**601 249 1574**	601 249 1868
❑ **Tupelo**	North MS Medical Center	**662 377 2374**	662 377 5787

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