



**Greene County Tobacco Control Program
“Always Bee Tobacco Free”**

3rd Floor, Fort Jackson Building, 19 S. Washington Street, Waynesburg, PA 15370
Phone: 724-852-5276 • Fax: 724-852-5368 • info@beetobaccofree.org • www.beetobaccofree.org

Tobacco Cessation Referral Form (For Greene County Patients 18 and Older)

1. Please provide patient-related information.

Healthcare Provider Name: _____ Phone: _____
Patient Name: _____ Gender: _____
Patient Phone: _____ Best Time to Call: _____

Please specify if the above patient does or does not have the following conditions:

YES	NO	Pregnant
YES	NO	Hypertension NOT controlled by medications
YES	NO	Heart Disease
YES	NO	Allergic to adhesive tape
YES	NO	Irregular heartbeat
YES	NO	Skin problems
YES	NO	Severe reaction to nicotine or nicotine patches
YES	NO	Takes medication for depression
YES	NO	Takes medication for asthma
YES	NO	Insulin dependent

The patient has indicated smoking/rubbing/chewing _____ per day.
(number of packs/pouches/cans)

2. Please check which cessation program the patient prefers:

- Bee Free Program:** 8 weeks of behavioral support through telephone coaching, support materials, and nicotine replacement therapy (NRT).
- SmokeStoppers®:** 4 weeks of behavioral support through group classes, support materials, and nicotine replacement therapy (NRT.)

3. Please check your recommendation for nicotine replacement therapy.

- Please DO NOT provide NRT. This patient may only participate in behavioral therapy services at this time.
- For **Bee Free:** Please provide NRT as offered by Partners in Corporate Health, Inc. (21mg/4 weeks, 14mg/2 weeks, 7mg/2 weeks; OR 14mg/6 weeks, 7mg/2 weeks; OR 8 week supply of NRT gum).
- For **SmokeStoppers®:** Please provide NRT as offered by the Greene County Tobacco Control Program (21mg/4 weeks, 14mg/2 weeks, 7mg/2 weeks).
- For **Bee Free or SmokeStoppers®:** Please provide NRT as follows (please note that any additional recommended NRT –other than the schedule provided by the cessation program – will need to be purchased by the patient): _____

4. Please authorize-and have patient authorize-us to proceed.

Signature of Healthcare Provider: _____ Date: _____

I give my permission to my healthcare provider to share my information with the tobacco cessation program.

Signature of Patient: _____ Date: _____

5. Please fax this form to the Greene County Tobacco Control Program at 724-852-5368. If you have any questions, please call Cheryl Andrews at 724-852-5276.