Mom's Quit Connection
Helping families live tobacco-free

2500 McClellan Avenue, Suite 250
Pennsauken, New Jersey 08109

856.665.6000 / 856.665.7711 fax
888.545.5191 toll-free
www.snjpc.org

Fax To

Please fax this form to MQC, then place original on patient's chart.

Date: _____

To: **Mom's Quit Connection**
Smoking Cessation Support Counselor

Phone: 856-665-6000 Fax: 856-665-7711

From: _____
Provider Name

_____
Hospital/Office Name

Phone: _____ Fax: _____

Email: _____

Pages including cover: _____

This section to be completed by client

Consent

I have been informed about Mom's Quit Connection, a FREE smoking cessation service for pregnant women and new mothers. I give permission for an MQC counselor to contact me and tell me more about the program. I understand that by having someone contact me, I am under no obligation to sign up for services. I understand that this form will be faxed to the MQC office.

Please Print:

First Name _____ Last Name _____

Street Address _____ Apt. No. _____

City _____ State _____ Zip Code _____ County _____

Call/Text (_____) _____ e-mail _____

Preferred call times _____
Mom's Quit Connection operates M-F, 8:30 am-5:00 pm

Date of Birth _____

Signature: _____

Stage of Readiness

Please check what best describes you:

- ❑ Ready to quit
- ❑ Willing to talk about quitting
- ❑ Want more information:
  - ❑ About quitting
  - ❑ About second hand smoke

Are You Pregnant?

- ❑ Yes Due Date: _____
- ❑ No

Do you now have or have you ever had diabetes?

- ❑ Yes
- ❑ No

Refer-to-Quit (Referral Form)

Fax form to: 1-866-QUIT-FAX (1-866-784-8329)

Tobacco-Free
FOR A HEALTHY NEW JERSEY

Step-by-Step:

- If a tobacco user would like help from the Quitline, complete form.
- Fax completed form to 1-866-784-8329.
- A Quitline Quit Coach will contact the tobacco user and offer free cessation services. A progress report will be sent to the provider listed on this form.
- The Quitline program is a free service for all New Jersey residents regardless of insurance status.

Code:
Special Programs Only

Tobacco Users: Complete This Section

(Please print)

First Name _____ Last Name _____ Date of Birth ____ / ____ / ____

Mailing Address _____ City _____ State ____ Zip Code _____

☐ Male ☐ Female Gender

( ) _____ - _____ Primary Phone (area code + number)

( ) _____ - _____ Secondary Phone (Area code + number)

E-mail Address: _____

When should we call? ☐ Morning ☐ Afternoon ☐ Evening ☐ No preference May we leave a message? ☐ Yes ☐ No

Language Preference: ☐ English ☐ Spanish ☐ Other (specify) _____

I (undersigned) give permission for the support staff of the New Jersey Quitline to contact me, coach me in quitting smoking, and give feedback regarding my progress to the provider/employer listed below and permission for that provider/employer to forward the information to other relevant providers.

_____ _____

Required Tobacco User's Signature (or agent if authorization was verbal) **Date**

Health Providers/Employer/Other: Complete This Section

Referrer: _____ ( ) _____ - _____ Phone number

Facility: _____ ( ) _____ - _____ Fax number

Address: _____ City _____ State _____ Zip _____

E-mail address: _____

SEND PROGRESS REPORT VIA SECURED: ☐ Secured Site Access ☐ E-mail (Secured Attachment)
☐ Fax (Provider Secured) ☐ DO NOT SEND PROGRESS REPORT (**If a selection is not indicated, no progress reports will be available**)

Send Progress Report to:

☐ Same as above or _____ ( ) _____ - _____
Name Phone number

_____ ( ) _____ - _____
Facility Fax number

E-mail address: _____

PEDIATRICS ONLY: Tobacco Users' relationship to child: ☐ Mother ☐ Father ☐ Other (specify) _____
Child/Children's name: (to help with recordkeeping) _____