

New Hampshire Division of Public Health Services
 NH Tobacco Helpline



- If a tobacco user is ready to quit in 30 days, fill out this form with them.
- A Quit Coach from the NH Tobacco Helpline will contact the individual to offer free treatment services, nicotine replacement therapy if available, and send feedback reports to the provider listed below.
- This program is free for all New Hampshire residents regardless of insurance status.

QuitWorks-New Hampshire Enrollment Form

Health Care Providers: Complete this section

| | | | |
|--|---|---------------------|----------------|
| Referring Provider: | Lata Thatai, MD, Karl D'Silva, MD, Cocav Rauwerdink, MD, Gabriele Southgate, MD | Phone Number | (603) 537-2060 |
| Facility: | Lahey Center for Oncology & Hematology at Parkland Medical Center | Fax Number | (603) 537-2359 |
| Address: | 6 Tsienneto Road, Suite 101LL, Derry, NH 03038 | | |
| Send feedback report to: | | | |
| <input type="checkbox"/> Same as above or | | | |
| | Name | Phone Number | Fax Number |
| PEDIATRICS ONLY: | | | |
| Tobacco User's relationship to child: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other (specify) _____ | | | |
| Child/Children's name: (to help with your recordkeeping) _____ | | | |

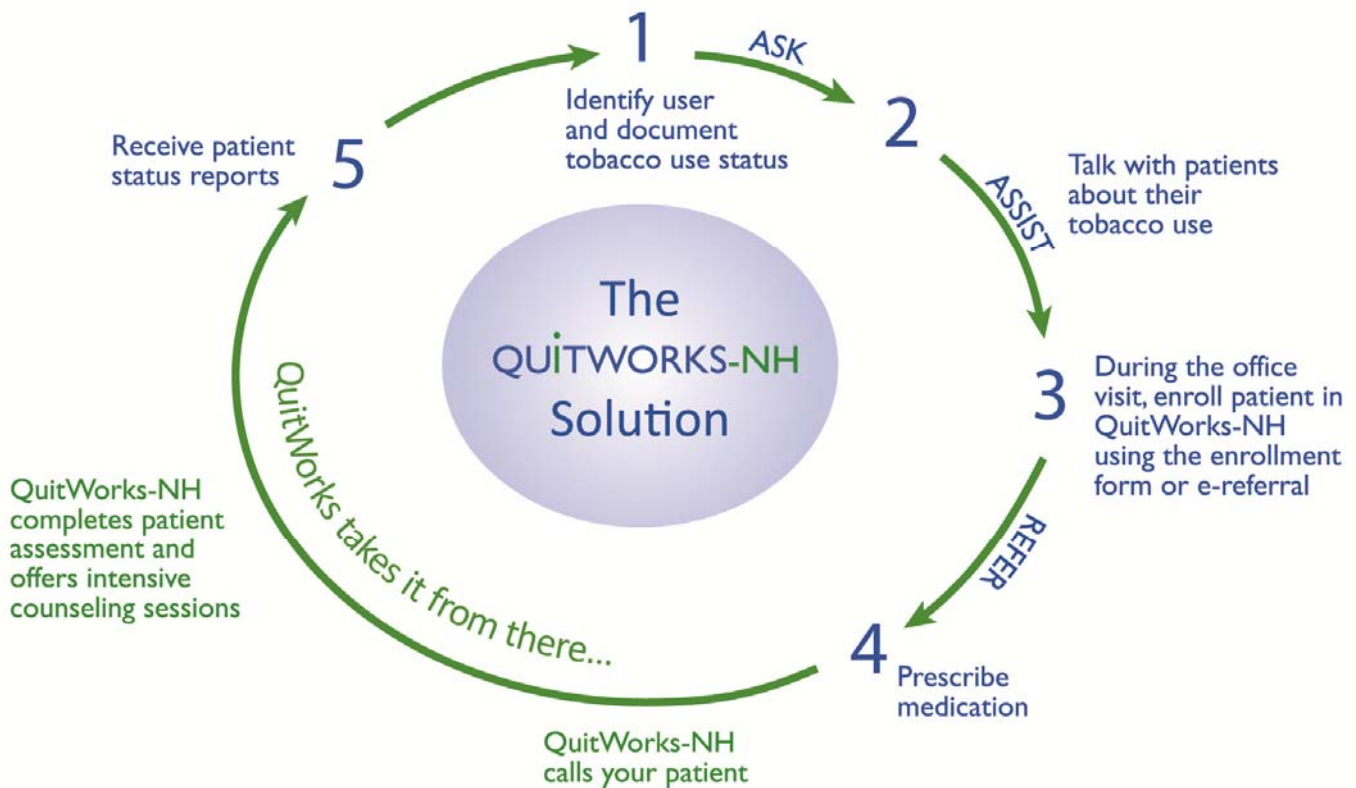
Health Care Providers: Complete this section (only necessary if one of the below conditions exists)

Does patient have any of the following conditions ? Pregnant/Breastfeeding Heart disease
 Uncontrolled high blood pressure

I authorize NH Tobacco Helpline to send patient free nicotine patches if available: _____

Patients: Complete this section

| | | | |
|---|-----------|--------|---------------|
| First Name | Last Name | Gender | Date of Birth |
| Mailing Address | City | State | Zip |
| Phone Number | | | |
| When should we call? (check all that apply) <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> No preference | | | |
| Language Preference: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (specify) _____ | | | |
| May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| <p>I authorize this provider to release the information on this enrollment form to QuitWorks-NH so that I may be contacted and participate in the QuitWorks-NH program. I also authorize QuitWorks-NH to disclose information about my progress in attempting to quit tobacco use to the health care provider listed on this form.</p> <p><input type="checkbox"/> By checking this box, this patient has consented to the above statement.</p> | | | |



**To request a customized form, contact the New Hampshire Division of Public Health Services, Tobacco Prevention and Control Program at: 1-800-852-3345 ext. 8949
Or email: tmbrown@dhhs.state.nh.us**