



Homecare

ILC

**BRIEF INTERVENTION GUIDE (for provider reference only)**

**ADVISE** to quit:  Advise smoker to quit.

**ASSESS** readiness:  Ready to quit  Thinking about quitting  Not ready to quit

**ASSIST** to quit:  Brief counseling: Reasons to quit • Barriers to quitting • Lessons from past quit attempts • Set quit date, if ready • Enlist social support

Medication, if appropriate Nicotine Replacement:  patch  gum  lozenge  inhaler  nasal spray

Other:  Bupropion (Zyban®/Wellbutrin SR®)  Varenicline (Chantix®)

**ARRANGE** follow-up:  Enroll in QuitWorks.

## Massachusetts Enrollment Form

**PROVIDER REFERRAL/FOLLOW-UP REPORT CONTACT**

Referred by: \_\_\_\_\_ PHONE (AREA CODE + NUMBER) \_\_\_\_\_  
PROVIDER NAME

\_\_\_\_\_ FAX (AREA CODE + NUMBER) \_\_\_\_\_  
FACILITY

\_\_\_\_\_ ADDRESS \_\_\_\_\_

Fax follow-up report to: Betty Maher, Homecare Assistance Program, MRC (617) 727-2809 (617) 204-3853  
NAME PHONE (AREA CODE + NUMBER) FAX (AREA CODE + NUMBER)

**QUITWORKS CLIENT**

FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_ DATE OF BIRTH (MONTH/DAY/YEAR) \_\_\_\_\_  
( )

PHONE (AREA CODE + NUMBER) \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_

May we leave a message?  YES  NO Language preference (check)  ENGLISH  SPANISH  OTHER (SPECIFY) \_\_\_\_\_

CLIENT ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**WHEN SHOULD WE CALL? QUITWORKS USUALLY CALLS WITHIN 3 BUSINESS DAYS OF RECEIVING THE REFERRAL.**

Check all that apply:  MORNING /  AFTERNOON /  EVENING /  NO PREFERENCE

**PRIMARY INSURANCE – check one**

<b>PRIVATE/COMMERCIAL</b>	<b>MASSHEALTH/MEDICAID</b>	<b>COMMONWEALTH CARE</b>	<input type="checkbox"/> <b>MEDICARE</b>	<input type="checkbox"/> <b>UNINSURED</b>
<input type="checkbox"/> Blue Cross/Blue Shield MA	<input type="checkbox"/> PCC Plan	<input type="checkbox"/> BMC Health Net	<b>SUPPLEMENTAL MEDICARE</b>	
<input type="checkbox"/> Harvard Pilgrim	<input type="checkbox"/> BMC Health Net	<input type="checkbox"/> Network Health	<input type="checkbox"/> Blue Cross/Blue Shield MA	
<input type="checkbox"/> Tufts Health Plan	<input type="checkbox"/> Network Health	<input type="checkbox"/> Fallon	<input type="checkbox"/> Fallon	
<input type="checkbox"/> Fallon	<input type="checkbox"/> Fallon	<input type="checkbox"/> Neighborhood Health Plan	<input type="checkbox"/> Tufts Health Plan	
<input type="checkbox"/> Health New England	<input type="checkbox"/> Neighborhood Health Plan		<input type="checkbox"/> Harvard Pilgrim	
<input type="checkbox"/> Neighborhood Health Plan	<input type="checkbox"/> Other MassHealth		<input type="checkbox"/> Other	
<input type="checkbox"/> Other				

**PEDIATRICS ONLY**

Relationship to client:  MOTHER /  FATHER /  OTHER (SPECIFY) \_\_\_\_\_

I \_\_\_\_\_ authorize this provider to release the information on this enrollment form to QuitWorks so that I may participate in the QuitWorks program. I authorize QuitWorks to contact me upon receiving this enrollment form from this provider. I also authorize QuitWorks and its representatives to disclose information about my progress in attempting to quit smoking to this healthcare provider and other follow-up contact designated by this provider.

\_\_\_\_\_  
SIGNATURE OF QUITWORKS CLIENT OR CLIENT'S REPRESENTATIVE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME OF QUITWORKS CLIENT REPRESENTATIVE

\_\_\_\_\_  
RELATIONSHIP TO CLIENT

Copies of this form may be downloaded at [WWW.QUITWORKS.ORG](http://WWW.QUITWORKS.ORG)  
**Fax this form toll-free to 1-866-560-9113**



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<input type="checkbox"/> Other				

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Yo, \_\_\_\_\_, autorizo por este medio al programa QuitWorks y a sus representantes para que divulguen la información necesaria para permitirme participar en el programa de asesoramiento para dejar de fumar tabaco que será proveído por este proveedor de cuidados primarios o por el contacto encargado del reporte al programa QuitWorks para dejarle saber a este proveedor primario del progreso de mi intento para dejar de fumar.

Yo autorizo a este Proveedor de salud la divulgación de la información contenida en esta hoja de inscripción al programa QuitWorks para los propósitos de mi participación en el mismo. Yo también autorizo a QuitWorks a que me contacten cuando reciban esta información que será proveída por este proveedor de salud.

\_\_\_\_\_  
FIRMA DEL CLIENTE DE QUITWORKS O REPRESENTANTES DEL CLIENTE

\_\_\_\_\_  
FECHA

\_\_\_\_\_  
NOMBRE IMPRESO DEL REPRESENTANTE DEL CLIENTE

\_\_\_\_\_  
RELACIÓN CON CLIENTE

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