



## Tobacco Treatment Enrollment A Collaboration of the Mass. Department of Public Health & Mass. Health Plans

- ADVISE smoker to stop:  Stop-smoking advice given: "I strongly advise you to quit smoking and I can help you."
- ASSESS readiness to quit:  Ready to quit  Thinking about quitting  Not ready to quit
- ASSIST smoker to quit:  Brief counseling  
Reasons to quit    Barriers to quitting    Lessons from past quit attempts    Set a quit date, if ready    Enlist social support
- Medications if appropriate  
Nicotine Replacement (CIRCLE): patch    gum    lozenge    inhaler    nasal spray    Other (CIRCLE): Bupropion (Zyban/Wellbutrin SR)
- ARRANGE follow-up:  Refer to Try-To-STOP TOBACCO Resource Center  
 by faxing the front of this form toll-free to **1-866-560-9113**.

### TRY-TO-STOP TOBACCO RESOURCE CENTER OF MASSACHUSETTS Massachusetts Resident Enrollment Form

REFERRAL SOURCE/FOLLOW-UP CONTACT			
referred by	NAME	SOUTHCOAST HOSPITALS GROUP	
	ADDRESS	363 Highland Avenue Fall River, MA 02720	
		phone (area code + number)	(508) 679-7015
		fax (area code + number)	(508) 679-7083
follow-up report contact		phone (area code + number)	fax (area code + number)
		( )	( )
PATIENT			
first name	last name		date of birth (month/day/year)
phone (area code + number)	May we leave a message?	language preference (circle)	
( )	<input type="checkbox"/> yes <input type="checkbox"/> no	English    Spanish    other (specify)	
email address			
patient address		city	state    zip
insurance <input type="checkbox"/> BCBSMA <input type="checkbox"/> BMC HealthNet Plan <input type="checkbox"/> Fallon <input type="checkbox"/> Harvard Pilgrim <input type="checkbox"/> MassHealth <input type="checkbox"/> Neighborhood Health Plan (NHP)			
<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Network Health <input type="checkbox"/> Tufts Health Plan <input type="checkbox"/> Other _____ <input type="checkbox"/> Uninsured			
THE RESOURCE CENTER USUALLY CALLS THE PATIENT WITHIN 3 BUSINESS DAYS OF RECEIVING A REFERRAL. WHEN SHOULD WE CALL?			
circle all that apply:	morning	afternoon	evening    no preference

I, \_\_\_\_\_, hereby authorize Try-To-STOP TOBACCO Resource Center of Massachusetts, (the "Resource Center"), and its representatives to disclose information about me to:

- 1) the American Cancer Society Quitline to the extent necessary to allow me to participate in its tobacco cessation counseling program; and
- 2) my primary care provider or other provider ("Provider") I designate to the Resource Center to the extent the Resource Center deems necessary to give my Provider an update of my progress in attempting to stop smoking.

I authorize my Provider to release the information on this enrollment form to the Resource Center for purposes of my participation in the QuitWorks program. I also authorize the Resource Center and its representatives to contact me upon receiving this referral from my Provider.

\_\_\_\_\_  
SIGNATURE OF THE PATIENT OR PATIENT'S REPRESENTATIVE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME OF PATIENT REPRESENTATIVE

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

### NICOTINE REPLACEMENT OPTIONS

#### \* PATCHES

Nicotine Transdermal 7 mg, 14 mg, 21 mg	Initial:	1 patch/24 hrs.	Treatment Duration: 8 wks.
	MAX:	Same as above	

#### \* GUM

Nicorette <sup>®</sup> 2 mg, 4 mg	Initial:	1 piece every 1–2 hrs.	Treatment Duration: 8–12 wks.
	MAX:	24 pieces/24 hrs.	

### NON-NICOTINE MEDICATION

#### \* BUPROPION HCL SR

Wellbutrin SR <sup>®</sup> 150 mg tablets	Initial:	150 mg/day (days 1–3) 300 mg/day (day 4+)	Treatment Duration: 7–12 wks.
	MAX:	300 mg/day	

#### VARENICLINE

Chantix <sup>®</sup>	Initial:	0.5 mg/day (days 1–3) 0.5 mg/2x/day (days 4–7) 1.0 mg/2x/day (day 8+)	Treatment Duration: up to 12 wks.
	MAX:	2 mg/day	

Inclusion of this adult dosage chart is strictly for the convenience of the prescribing provider. Please consult the Physicians' Desk Reference for complete product information and contraindications. This chart does not indicate or authorize insurance benefit coverage for any of these medications. For insurance benefit information, the patient will need to contact his/her insurer directly. The cost or provision of these medications is not included as any part of the Try-To-STOP TOBACCO Resource Center of Massachusetts or QuitWorks program.

\* GENERALLY AVAILABLE FROM HOSPITAL PHARMACY.

I hereby authorize Southcoast Hospitals Group to make a one time disclosure of the information specified on this form to the Try-To-Stop Tobacco Resource Center of Massachusetts.

I understand that I may revoke this authorization at any time by requesting such from Southcoast in writing, unless it has been acted on already. This authorization will expire after the disclosure is made.

I may refuse to sign this authorization. My health care, payment for my health care, and my health care benefits will not be affected if I do not sign this form (except for the referral to the Try-To-Stop Tobacco Resource Center). I have the right to receive a copy of this authorization after I sign it.

I understand that the information disclosed pursuant to this authorization could be re-disclosed by the recipient and if so may not be subject to federal and state law protecting its confidentiality.

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accepted all of the terms in the authorization form and authorize the disclosure of my protected health information as described on this form.

\_\_\_\_\_  
SIGNATURE OF THE PATIENT OR PATIENT'S LEGAL REPRESENTATIVE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME OF PATIENT REPRESENTATIVE

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

## Make smoking history.