QUITLINE HEALTHCARE REFERRAL PARTNER REGISTRATION FORM

ILLINOIS TOBACCO QUITLINE
ILLINOIS DEPARTMENT OF PUBLIC HEALTH
AMERICAN LUNG ASSOCIATION IN ILLINOIS

COMPLETE THIS FORM TO REGISTER AS A QUITLINE REFERRAL PARTNER.
Return this form by fax to 217-787-5916 or e-mail to info@quityes.org.

A. PARTNER INFORMATION

Facility Name _____ Department/Division _____

Contact Person Name _____ Title _____

Address _____

City _____ State _____ Zip _____

County _____ Telephone _____ Fax _____

E-mail Address _____

B. FACILITY INFORMATION

Facility Type

- ☐ Local Health Department
- ☐ Private Physician Office
- ☐ Community Health Center
- ☐ Community-Based Organization
- ☐ Federally Qualified Health Center (FQHC) — including all divisions, e.g., dental clinic, mental health, of the FQHC or Rural Health Center
- ☐ Hospital (Public or Private)
- ☐ Dental Health Provider
- ☐ Mental Health Provider
- ☐ Other (please specify)

Will the referral program be implemented across the entire facility or only in select divisions?

- ☐ Entire facility
- ☐ Select divisions

Please specify _____

C. REFERRAL METHOD

- ☐ Paper fax
- ☐ Electronic fax

D. HOW DID YOU HEAR ABOUT THE QUITLINE REFERRAL PROGRAM?

- ☐ Local Health Department Representative
- ☐ American Lung Association Representative
- ☐ Current Referral Program Partner
- ☐ Conference Exhibit/Presentation
- ☐ Online
- ☐ Other _____

FOR OFFICE USE: Date received_____ Orientation conducted by _____ on_____

Entered into GMEE Datatbase ☐ Yes ☐ No Tracking ID _____

Treatment form created ☐ Yes ☐ No Treatment form sent to partner ☐ Yes ☐ No