



FAX BACK #: (\_\_\_) \_\_\_-\_\_\_

Referred By: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_) \_\_\_-\_\_\_

Check appropriate organization:

- Right From The Start
- Wellness Council
- BCCSP
- Tobacco Free Pregnancy Initiative
- WISEWOMAN
- Rainbow (LGBT)
- Head Start     Other: \_\_\_\_\_

### Participant Consent and Personal Information Section:

I understand that the WV Tobacco Quitline will be contacting me with quit tobacco information, community referrals and/or counseling. My participation is voluntary. I understand that any information I provide will be kept confidential. I give The WV Tobacco Quitline and/or the referring organization permission to discuss my referral.

Participant Name (please print): \_\_\_\_\_

Phone: (\_\_\_) \_\_\_-\_\_\_

Participant or Guardian Signature: \_\_\_\_\_

Home     Work     Cell

Verbal Consent Received (if no signature above)

Best Time to Call:

Person Obtaining Verbal Consent (sign and print): \_\_\_\_\_

8am to 12pm

12pm to 5pm

Date of Birth: \_\_\_/\_\_\_/\_\_\_

5pm to 8:30 pm

County of Residence: \_\_\_\_\_

Specific: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

May We Leave a Message?:

If Medicaid, ID#: \_\_\_\_\_

Yes     No

### QUITLINE USE ONLY

Participant Enrolled  Unable to Reach Participant

Date: \_\_\_/\_\_\_/\_\_\_