Available to Patients with Primary Care through:

Cooley Dickinson affiliated providers or **Valley Medical Group providers**

2020 Referral for **Quitters Win** Smoking Cessation

REQUIRED INFO: **PCP** _____

Referring Provider (if different than PCP) _____

Patient Name_____ **DOB**_____

Home Ph._____ **Cell Ph.**_____

Patient is interested in:

☐ Weekly **Virtual QuittersWin** Facilitated Support Group
Wednesdays at 4:00pm on Zoom
First time attendees should attend 3:30 orientation session (1 time only)

☐ Patient initiated Telephone Coaching
(Available Most Mon, Tue, Wed, 7:30 am to 3:00 pm)

☐ Text Message Support (2-3 texts per week)

Comments:_____

OPTIONAL INFO:

Tobacco History

Current Pack years: _____ Age of onset: _____

Quit Attempts_____ Quit Modalities tried_____

For internal use only Rec'd: _____ 1st try: _____ 2nd try: _____ 3rd try: _____

Comments: _____

☐# entered ☐intro phone sched sent ☐intro BESO sent ☐delivery confirmed ☐_____ ☐_____

Schedule Orientation: Start Date _____

Please FAX completed form to: ATTN Tim Sweeney **Secure FAX# 413-772-3397**