Susan C. Kelly, RS
Health Officer

Russell W. Moy, MD, MPH
Deputy Health Officer

HARFORD COUNTY HEALTH DEPARTMENT

CRF Tobacco Program Office Location: 1321 Woodbridge Station Way, Edgewood, MD 21040

Physician Referral Form

Nicotine Replacement Therapy Program

Thank you *for supporting your patient's tobacco cessation efforts. A three minute tobacco cessation intervention performed by a patient's personal physician is frequently a deciding factor in a user's decision to become tobacco-free.*

Your Patient: _____ **D.O.B.** _____

Phone # _____ **Address:** _____

may be eligible to receive free nicotine replacement therapy supplies from the Harford County Health Department. This patient must be enrolled in the Health Department's Tobacco Cessation Program, a requirement in order to receive NRT supplies. If the patches, lozenges or gum are appropriate therapy for this patient, fill out this form in its entirety and return to the Health Department by FAX 410-612-9184 or by mail to the mailing address above.

TO BE FILLED OUT BY PHYSICIAN:
I have examined my patient and found him/her to be medically eligible to use nicotine replacement therapy.

Unless otherwise specified by you, your patient will receive up to ten weeks of nicotine patches, lozenges or gum.
Special Instructions:

_____

_____

Please check off which of the following levels of nicotine replacement therapy you feel the patient should begin using:

PATCHES	or	LOZENGES	or	GUM	or	**COMBINATION**
_____ 21 mg (for 4-6 weeks)		_____ 4 mg		_____ 4 mg		(Possible for more than pack a day smokers)
_____ 14 mg (for 2-3 weeks)		_____ 2 mg		_____ 2 mg		_____ 21mg patches PLUS 2mg gum
_____ 7 mg (for 2-3 weeks)						or 2 mg lozenges

Please read and initial below:

_____ **I have made my patient aware of the risks and benefits of using nicotine replacement therapy to end tobacco usage.**

_____ **As the attending physician, I will be responsible for the medical management of my patient while they are using nicotine replacement therapy.**

Physician's Signature _____
Physician's Name (Print) _____
Physician's Phone # (including area code) _____
Date _____/_____/_____

Please return form to:

Harford County Health Department Cigarette Restitution Fund (CRF) Tobacco Program
Phone: 410-612-1781 Fax: 410-612-9184 Fax

3/13/12