Public Health
Prevent. Promote. Protect.
Harford County Health Department

Harford County Health Department

Main Office: 120 S. Hays Street • P.O. Box 797 • Bel Air, Maryland 21014

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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 Treatment 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 Woodbridge Station Way address below. Please provide a copy of this form to your client.

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 twenty 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 users)
_____ 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_____ /_____ /_____

Harford County Health Department Tobacco Program Phone: 410-612-1781 FAX 410-612-9184