PHONE: (410) 819-5600
TOLL FREE: 1-877-810-7184

FAX: (410) 819-5690
TTY: 1-800-735-2258 MD

100 S. HANSON STREET, EASTON, MD 21601
Fredia S. Wadley, MD, Health Officer

Physician Referral Form

Tobacco (Nicotine) Cessation Program

Patient Name:	**DOB:**
Address:	**Phone:**

As a patient, I have shared all medications that I am currently taking with the above mentioned caregiver and accept full responsibility for following the instructions of the chosen quit aid medication in order to ensure a safe tobacco cessation experience. I therefore release Talbot County Health Department and its staff from all liability.

_____ _____

Signature of Patient Date

TO BE FILLED OUT BY PHYSICIAN:

The Talbot County Health Department's Tobacco Program will provide Chantix, bupropion SR, Nicotine patches, gum, or lozenges, for up to 12 weeks of treatment, **provided** the participant is enrolled in the Smoking Cessation Program.

Before distributing the medication or vouchers, your patient is required to obtain medical clearance. Please determine if your patient can safely participate in this program. If yes, please determine the best course of action for your patient, and **provide prescriptions if indicated:**

☐ **Chantix:** write an Rx for a starter pack, and an Rx for a continuation pack, with 1 refill, for a total of 12 weeks of Chantix

☐ **Bupropion SR:** write an Rx for 150mg tablets, once a day for 3 days, then twice a day until completed, with refills for a total of 12 weeks

☐ **Please circle one** **Nicotine Patches only**
Nicotine Patches and Gum
Nicotine Patches and 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.***

There are no medical contraindications for this patient to participate in the Talbot County Health Department's Tobacco Cessation Program. A prescription for a 12-week supply of either Chantix or bupropion SR is attached, if needed.

Physicians Name (Print):	**Phone:**
Physician's Signature:	**Date:**