

Physician to Complete

Date of Referral: _____

Patient Name: _____ DOB: _____

Patient's Home Phone Number: _____ Alternate Number: _____

Address: _____

Referring MD: _____ Follow-up (managing) Physician: _____

Office Fax Number to send patient smoking cessation clinic information: _____

PLEASE ATTACH MOST RECENT HISTORY AND PHYSICAL AND LABORATORY DATA IF THAT INFORMATION IS NOT AVAILABLE IN THE EVERGREENHEALTH CERNER COMPUTER SYSTEM.

PLEASE COMPLETE THE FOLLOWING INFORMATION

- Diagnosis/conditions as indications for smoking cessation referral (must be completed):
 COPD Diabetes High Blood Pressure PVD Cancer Heart Disease
 Lung Disease/Asthma Stroke other _____
- Complicating Factors(actual or history of):
 Pregnant/lactating Psychiatric illness suicidal ideation CKD Seizure disorder
 Cardiac arrhythmias Bulimia/anorexia recent MAOI use Cirrhosis
 Recent MI
- Activity Restrictions: _____
- Years smoked: _____ Packs per day: _____ Previous quit attempts: _____


EvergreenHealth Smoking Cessation Clinic will use a combination of counseling and pharmacological therapy that may include bupropion, varenicline and nicotine replacement therapy. Varenicline use will be discussed with the referring provider prior to prescription. Please indicate if any other pharmacological therapies are contraindicated in the patient.

Physician/Advanced Practice Clinician Signature*	Date	Time

*Signature indicates provider's order for evaluation and management of above related conditions via smoking cessation therapy by EvergreenHealth Pharmacists, assignment of benefits to EvergreenHealth and authorization for the use of Washington State Department of Health, Pharmacy Commission submitted collaborative therapy agreement. Ordered Frequency of Laboratory Tests and Evaluation/Monitoring Clinic Visits: Per treatment plan schedule.

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Smoking Cessation Clinic (within Evergreen's Pharmacist Provider Services)
Phone: (425) 899-2783 Fax: (425) 899-2784 Please fax completed referral forms


 EvergreenHealth
 Kirkland, WA 98034
SMOKING CESSATION CLINIC
REFERRAL and PHYSICIAN ORDER
 FORM ID RX XXX
 Approved: XX/XXXX

APPLY PATIENT LABEL HERE
 Original/Fax – Patient Clinic Chart Copy – Medical Records