



## QuitlineNC Referral Site Registration

### Explanations and Instructions to Complete Registration Form

Please **PRINT** clearly

**ALL INFORMATION IS REQUIRED**

**Site Name-** The name of the specific program, unit, location etc., registering for use of the fax referral by clinicians they employ. **If part of a larger health system, also include the name of the larger system or location to which your site belongs.** To get the most accurate outcome data from QuitlineNC, this name must be used on all fax referral forms from the site.

**Mailing Address-** the complete mailing/shipping address.

**Referral Site Main Phone Number:** This is the telephone number for the site making the referral.

**Referral Site Fax Number-** this number is used when QuitlineNC faxes back patient's referral outcomes if an email address is not listed.

**Type of Site-** Indicate the kind of setting that refers people to the QuitlineNC. If you are part of a larger organization but are registering as a separate site, pick the type of setting that best fits your department's work. As an example: a psychiatric inpatient unit inside of a medical hospital would select: "Inpatient psychiatric unit or hospital" If you are registering a site that has a variety of programs with in it, select the best option to describe your entire site. As an example, to register an entire hospital as one site select: "inpatient unit or hospital".

**Contact Person-** The designated contact for QuitlineNC to work with to resolve any problems with web referrals, send reports and update on QuitlineNC services. The Contact Person does not need to be the clinician referring the patient to the QuitlineNC (e.g., the Contact Person might be the Office Manager). Patient referral outcome information will be sent securely by QuitlineNC to the fax number, secured email or provided by the contact person **who may need to forward it to the referring clinician.**

**Position/ Job Title-** the position or job title of the Contact Person (license and/or credentials may be included here).

**Contact Person's Email-** the email address to use if/when we need to send a message to the Contact Person. NC TPCB will mail aggregate data on all fax referrals to the Contact Person monthly.

**Contact Person's Phone Number-** The best phone number to call to reach the contact person directly.

**Indicate if this is a HIPAA compliant provider as defined by HIPAA.**

Return completed form to NC TPCB by email to: [mariam.ali@dhhs.nc.gov](mailto:mariam.ali@dhhs.nc.gov)

**[www.quitlinenc.com](http://www.quitlinenc.com)**

# QUITLINE REFERRAL SITE REGISTRATION FORM



**PLEASE PRINT CLEARLY- ALL INFORMATION IS REQUIRED**

Site Name: \_\_\_\_\_

Is this site part of a larger healthcare/behavioral health organization or system?

If yes (provide name): \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ Zip code \_\_\_\_\_

Referral Site Phone Number: \_\_\_\_\_

Referral Site **FAX NUMBER**: \_\_\_\_\_

What kind of Electronic Medical Record (EMR), if any, does your site use: \_\_\_\_\_

### Type of Site (select only ONE)

(Mark X)	Medical Sites
	Health department
	Free clinic
	Community Health Center
	Adult primary care
	Pediatrics/family medicine primary care
	Inpatient unit or hospital
	Outpatient specialty care
	Skilled nursing facility
	Dental clinic

(Mark X)	Behavioral Health Sites
	Inpatient psychiatric unit or hospital
	Inpatient substance use treatment unit/hospital
	Residential substance use treatment facility
	Residential behavioral health facility
	Outpatient substance use treatment program
	Outpatient behavioral health clinic/program
	Other: (specify here):

Other: (specify here):
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Indicate how your clinic currently sends referrals (Mark X to the one that applies)?

Fax \_\_\_\_\_ If using Fax, how many fax machines send referrals to the QuitlineNC? \_\_\_\_\_

EMR \_\_\_\_\_

Scan form & send via secured email \_\_\_\_\_

We have not sent referrals before now \_\_\_\_\_

If you use your EMR for referrals do you (please mark X to the one that applies):

\_\_\_ Use it to download the fax form & print it out

\_\_\_ Have it fax the information to the QuitlineNC for you (you make a note in the patient's chart and route it the QuitlineNC fax number)

\_\_\_ Use it to send a secured email to the QuitlineNC (you make a note in the patient's chart and it securely emails it to the QuitlineNC)

Indicate the approximate percentage of people your site serves with the following types of insurance:

Medicaid\_\_\_% Medicare\_\_\_% Uninsured\_\_\_%

What percentage of the clients you serve are pregnant women? (if unsure, indicate your best estimate):

\_\_\_\_%

Contact Person: \_\_\_\_\_

Position/ Job Title: \_\_\_\_\_

Contact Person's Phone Number: ( ) \_\_\_\_\_

Contact Person's Email Address: \_\_\_\_\_

What is the BEST way to contact you? \_\_\_\_\_

Is your clinic/practice/ agency HIPAA compliant? (underline one):        YES   /   NO

EMAIL THIS FORM TO:

Mariam Ali, QuitlineNC Referral Site Coordinator and Joyce Swetlick, Director of Tobacco Cessation  
North Carolina Tobacco Prevention and Control Branch (NC TPCB)

[mariam.ali@dhhs.nc.gov](mailto:mariam.ali@dhhs.nc.gov)

[joyce.swetlick@dhhs.nc.gov](mailto:joyce.swetlick@dhhs.nc.gov)

Questions – Call- 919-360-9336 or 919-707-5402

[www.quitlinenc.com](http://www.quitlinenc.com)