Referral site representative: Please have interested person complete, then you, the representative, **fax this form** to **865-215-5148**.

Power to Quit Program – Permission to Contact

Referral Site Information:

Organization Name:	
Organization Contact Person:	
Phone:	**Email:**

Interested Person Information, including Personal Health Information – Please Print

First Name:	**Last Name:**	**_____ weeks pregnant**
Mailing address:	**City:**	**State/ZIP:**
Phone:	**Email:**	
Are you smoking? ☐ **YES** ☐ **NO – I quit at ___ weeks of pregnancy and can have my doctor confirm**	**What is the best way to contact you?** ☐ **Phone** ☐ **Email** ☐ **No preference**	

A representative in Community Health at the Knox County Health Department can call me (if preferred) during the following times (check all that apply):

☐ **7am-10am** ☐ **10am-1pm** ☐ **1pm-4pm** ☐ **4pm-7pm** ☐ **7pm-10pm**

I give my consent for the representative at the referral site to give my information to a representative in Community Health at the Knox County Health Department. The staff person has permission to call and/or email me.

Signature: _____ **Date:** _____

Follow-up Information:

Internal Use Only:

☐ Patient was contacted and has declined services ☐ Patient was not contacted after multiple attempts

☐ Patient was contacted and registered for CO Screening Program

Introductory session scheduled - **Date/Time:** _____ **Location:** _____