



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:** \_\_\_\_\_

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