Asthma and COPD Center

THE UNIVERSITY OF CHICAGO

TOBACCO CESSATION PROGRAM FAX REFERRAL

Quit rates are highest when medications are combined with behavioral intervention.

Please complete **ITEMS 1-5 (all items required)** and **fax to the Asthma & COPD Center at 773-834-0242. Please print legibly.** We will call the patient to schedule an outpatient appointment.

1. Today's date: _____ _____ _____
   Month Day Year

2. Patient Info: _____ _____
   Name: First, Last Phone

3. Referral by: _____ _____
   Physician/Nurse name - First, Last Fax #

** If this is a self referral, please write "self"**

4. Primary Care Physician or other provider to whom we should send our consultation report: _____ _____
   Provider Name - First, Last Fax #

   _____
   Address

   _____
   City State, ZIP

5. Diagnosis (please check one):

- ☐ Asthma
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Sarcoid
- ☐ Idiopathic Pulmonary Fibrosis (IPF)
- ☐ Congestive Heart Failure (CHF)
- ☐ Coronary Artery Disease
- ☐ Other: _____