



Tobacco Cessation Referral Form

I am recommending: _____

(First Name)

(MI)

(Last Name)

(DOB)

(Best Contact Number)

enroll in the Tobacco Cessation Program based on the following eligibility criteria:

Exercise Limitations:

None

Limitations: _____

Health Care Provider Information:

Signature: _____ Date: _____

Name: _____ Provider NPI: _____

Address: _____

Phone: _____ Fax: _____

Please fax this form to:

Beaufort County Health Department

Kamryn Boyce

1436 Highland Drive, Washington NC

(P) 252-940-5093 (F) 252-946-8430

kamryn.boyce@bchd.net