



**888.545.5195 toll free**  
**856.665.7711**  
**momsquit.org**

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 888.545.5191 toll-free  
 www.snjpc.org

# Fax To

Please fax this form to MQC, then place original on patient's chart.

Date: \_\_\_\_\_

To: **Mom's Quit Connection Smoking Cessation Support Counselor**

Phone: **856-665-6000** Fax: **856-665-7711**

From: \_\_\_\_\_  
*Provider Name*

\_\_\_\_\_ *Hospital/Office Name*

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

# Pages including cover: \_\_\_\_\_

**THIS SECTION TO BE COMPLETED BY CLIENT**

## CONSENT

I have been informed about Mom's Quit Connection, a FREE smoking cessation service for pregnant women and new mothers. I give permission for an MQC counselor to contact me via phone, text, email or mail and tell me more about the program. I understand that by having someone contact me, I am under no obligation to sign up for services. I understand that this form will be faxed to the MQC office.

### PLEASE PRINT:

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Street Address \_\_\_\_\_ Apt. No. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_

Phone/Text (\_\_\_\_\_) \_\_\_\_\_ e-mail \_\_\_\_\_

Preferred call times \_\_\_\_\_  
*Mom's Quit Connection operates M-F, 8:30 am-5:00 pm*

Date of Birth \_\_\_\_\_

Signature: \_\_\_\_\_

### STAGE OF REDINESS

Please check what best describes you:

- Ready to quit
- Willing to talk about quitting
- Want more information:**
  - About quitting
  - About second hand smoke

### Are you pregnant?

- Yes Due Date: \_\_\_\_\_
- No

### Do you now have or have you ever had diabetes?

- Yes
- No

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