Quit Now Virginia
Tobacco User Quitline

QUITLINE REFERRAL SITE REGISTRATION FORM

*All information is required

Site Name: _____

Mailing Address: _____

City: _____ County: _____ Zip code_____

Fax Number: _____

Contact Person: _____

Position / Job Title: _____

Phone Number: _____ E-mail Address: _____

Is your practice HIPAA compliant? YES ◯ / NO ◯

Type of Site (select only ONE)

Select	Medical Sites	Behavioral Health Sites	Select
	Health Department	Inpatient Psychiatric Unit or Hospital	
	Free Clinic	Inpatient Substance Abuse Treatment Unit or Hospital	
	Community Health Center	Residential Substance Use Treatment Facility	
	Family Practice – Pediatrics, OB/GYN, etc.	Residential Behavioral Health Facility	
	Inpatient Unit or Hospital	Outpatient Substance Abuse Treatment Program	
	Outpatient Specialty Care	Outpatient Behavioral Health Clinic or Program	
	Dental Clinic	Community Service Board (CSB)	
	Federally Qualified Health Center (FQHC)		
	College or University		
	Worksite or Business		
	Faith-based Organization		
	Other (please specify):	Other (please specify):	

Return completed form to **quitnowva@vdh.virginia.gov**

Questions/Comments - 804-864-7897

You will receive an e-mail with a registration packet and access link to the E-referral portal.
This E-referral service allows sites to refer patients electronically through a web portal.

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Quitline Referral Site Registration Instructions

Please print clearly. All information is required.

Site Name
The name of the clinic, practice, organization, (etc.) registering for the fax referral system.
If part of a larger health system, please include the name of the specific site or unit within that system.

Mailing Address
The complete mailing/shipping address to which you will receive materials. *No P.O. boxes.

Fax Number
This number will be used to receive patient outcomes from Optum, the quitline service provider.

Contact Person
This person will receive patient outcomes from Optum, the quitline service provider.
This does not need to be the referring clinician (e.g., the Contact Person might be the Office Manager).

Position / Job Title
The position or job title of the Contact Person (license and/or credentials may be included here).

Phone Number and E-mail
The e-mail address provided will receive aggregate data on all fax referrals on a monthly basis from VDH.

Indicate if this is a HIPAA compliant provider
Yes/No

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