



# Culinary "Call it Quits" Program - Referral Form

### Type of Program

Helpline   
  Online   
  Onsite Class

Date \_\_\_\_\_

### Referred by

Physician                       CEC  
 Customer Service               Union  
 Advocacy                           Dental Office  
 ALA                                       Other \_\_\_\_\_

### Physician Information

Name:			
Address:	City:	State:	Zip:
Phone:	Fax:		

### Participant Information

Name:	MI:	Last Name:	Social Security #:
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### Patient Information

Name:	MI:	Last Name:	Date of Birth:
Address:	City:	State:	Zip:
Home Phone:	Work Phone:	Cell:	E-Mail:
Best time to call (please circle one):			
Morning	Afternoon	Evening	
Is the patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (Male)			
Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other			

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*In lieu of patient signature, patient has verbally agreed to have the CHF Advocate forward their contact information to the ALA Helpline\*\*\*

**Please fax to: (702) 691-5620**

## For office use only

\_\_\_\_\_  
Received by

\_\_\_\_\_  
Date Received

\_\_\_\_\_  
Unique ID

\_\_\_\_\_  
Date Forwarded  
to ALA

\_\_\_\_\_  
Alias

\_\_\_\_\_  
Date Input in  
database