Wicomico County Health Department

108 East Main Street
Salisbury, Maryland 21801
410-749-1244
FAX: 410-543-6975
TDD: 410-543-6952
LORI BREWSTER, M.S., APRN/BC, LCADC
HEALTH OFFICER

PATIENT MEDICAL CLEARANCE FOR PARTICIPATION IN THE TOBACCO CESSATION PROGRAM

CHANTIX

Re: **Patient: _____ SS#: _____**

(DOB: _____)

The Wicomico County Health Department's Tobacco Program will provide vouchers redeemable for **Chantix** every 4 weeks, for up to 8 weeks of treatment, **provided** the participant attends eight counseling sessions. The patient will pay $10 per voucher to Community Pharmacy. No co-pay is required for sessions held at businesses.

Before distributing the vouchers, your patient is required to obtain medical clearance. Please determine if your patient can safely participate in this program. If yes, **write a Rx for a starting month pak and continuing month pak, for a total of 8 weeks of Chantix** and complete the form below. Your patient will then bring both to the Health Department in order to begin treatment.

Twelve weeks after their initial visit, you will be notified in writing of their progress. If you have any questions, please call Jennifer Johnson or Sara Seitz, at 410-546-5311.

There are no medical contraindications for this patient to participate in the Wicomico County Health Department's Tobacco Cessation Program. A prescription for an 8-week supply of __CHANTIX____ is attached.

_____ _____
Print Physician's name Phone #

_____ _____
Signature of Physician Date

As a patient, I have shared all medications that I am currently taking with the above mentioned caregiver and accept full responsibility for following the instructions of the chosen quit aid medication in order to ensure a safe tobacco cessation experience. I therefore release Wicomico County Health Department and its staff from all liability.

_____ _____
Signature of Client Date

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