



# 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

### PATCHES and ZYBAN

Re: **Patient:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**(DOB:** \_\_\_\_\_ **)**

The Wicomico County Health Department's Tobacco Program will provide vouchers redeemable for **either generic transdermal nicotine patches or Zyban** every 2 weeks, for up to 10 weeks of treatment, **provided** the participant attends eight counseling sessions. The patient will pay \$5 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 either the patches or Zyban and complete the form below. Your patient will then bring both to the health department to begin their treatment. **If patches are ordered, specify the doses for the entire 10 week period (e.g., 21 mg. - 4 weeks., 14 mg. - 4 weeks., 7 mg. - 2 weeks).**

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 a 10-week supply of \_\_\_\_\_ 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

/j:myfiles/referral ltr 2002;03,7/03,8/04,01/07, 12/08