

**SOMERSET COUNTY HEALTH DEPARTMENT**

**Stop Smoking Program**

***Rx/Medical Clearance – CHANTIX***



Date

Client Name DOB

Address

Phone SSN# - -

Dear Health Care Provider:

The client named above is interested in joining the smoking cessation program offered by the Somerset County Health Department, which provides cessation counseling and a choice of either Chantix or the nicotine replacement patch (generic) at no cost. **The client reports smoking cigarettes per day and would like to use Chantix.**

**By signing this form, you acknowledge that this patient is medically cleared to receive the cessation medication indicated, in the dosage indicated:**

🡺

**Chantix (one starting pack of .5mg and two continuing packs of 1mg)**

***Complete Provider information:***

Name:

Address:

Phone: Fax:

🡺

DEA #: NPI #:

***Provider Signature (required):***

*Signature Date*

**PLEASE RETURN THIS FORM TO YOUR PATIENT**

*For more information about this program, call*

*443-523-1760*

*Somerset County Health Dept.*

*7920 Crisfield Hwy., Westover, MD 21871*

sel 3/2017



**SOMERSET COUNTY HEALTH DEPARTMENT**

**Stop Smoking Program**

***Rx/Medical Clearance – PATCH***



Date

Client Name DOB

Address

Phone SSN# - -

Dear Health Care Provider:

The client named above is interested in joining the smoking cessation program offered by the Somerset County Health Department, which provides cessation counseling and a choice of either Chantix or the nicotine replacement patch (generic) at no cost. **The client reports smoking cigarettes per day and would like to use the nicotine patch.**

**By signing this form, you acknowledge that this patient is medically cleared to receive the cessation medication indicated, in the dosage indicated:**

🡺

**Nicotine replacement patch (21mg for 4 weeks, 14mg for 4 weeks, 7mg for 4 weeks)**

***Complete Provider information:***

Name:

Address:

Phone: Fax:

🡺

DEA #: NPI #:

***Provider Signature (required):***

*Signature Date*

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