



**Smoking Intervention Program (SIP)
Consult Form - In Network
(313) 874-1885**

DATE: _____

MRN: _____

NAME: _____

Referring Physician to Complete

Requesting Provider:(print) _____ Specialty: _____

Clinic Phone # (____) _____ Fax # (____) _____ Clinic/Inpatient Unit _____

Patient Phone Number: (____) _____ Best Time to call: _____

Patient email address: _____

HAP Member: Yes No

CO-MORBIDITY PRESENT?

None

Asthma

Chronic obstructive pulmonary disease

Diabetes Mellitus

Post-myocardial infarction

Pregnancy

Substance abuse

Other: _____

Cancer

Depression

Nursing mother

Psychiatric disorder

Renal impairment

Severe cardiovascular disease

MEDICATION:

Check one of the following 2 options:

I authorize the SIP Medical Advisor to prescribe medication to patient.

Treatment options include: nicotine patch, nicotine gum, nicotine spray, nicotine lozenge, nicotine inhaler, Bupropion and Varenicline

Please indicate if patient has any of the following potential contraindications:

Less than 4 weeks post myocardial infarction

Serious arrhythmia

Severe angina

Seizures

Epilepsy or family history of epilepsy

Brain surgery

Brain tumor

Significant head injury

Stroke

Concurrent use of Monoamine Oxidase (MAO) inhibitor

None of the above

I prefer to prescribe medication to patient. Please list medications you have prescribed (including

over-the-counter): _____

Physician (print) Signature

Date

Time AM / PM

FAX COMPLETED FORM TO (313) 874-6880