

# Referral For Smoking Cessation Program

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Date

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Referring Doctor's Name

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Office Street Address

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City

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State

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Zip

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Phone

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Email

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Patient Name

This letter is to refer the above named patient to a smoking cessation specialist.

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Signature

Please give this form to the patient or you may fax this form directly to Dr Cort Curtis at  
**(877) 372-8784**