

Tobacco Fax Referral Training

Request Form

Contact Information

Organization Name: _____

Contact Person: _____

Job Title: _____

Phone: () - Fax: () -

Email: _____

Practice Information

Name of practice (if different from above): _____

Senior/Lead Physician: _____

Address: _____

City: _____ County: _____

State: _____ Zip: _____

Total number of staff (non-providers) for this practice site: People: _____ FTE: _____

Total number of providers for this practice site: _____

Please provide a general description of the clinical practice setting, for example:

- Family Medicine / Internal Medicine / Pediatric / Specialty / Other
- Solo or group practice
- Private practice / public clinic / Federally Qualified Health Center
- Hospital-based
- Other

Type of Records **(circle one)**: EMR Paper

Practice Patient Population Information

1. On average, how many patients are seen in the practice per day: _____

2. Approximately how many patients are in your practice: _____

3. Please give the approximate percentage of your patients in the following age categories:

- 0-18 _____%
- 19-44 _____%
- 45-65 _____%
- 65 and over _____%

4. Approximate percentage of patients (not revenue) in the following payor category:
Uninsured , Medicaid, and Sliding Scale _____%

5. Approximate percentage of patients in the following racial/ethnic categories:

- a) Hispanic or Latino _____%
- b) White non-Hispanic _____%
- c) Black / African American _____%
- d) American Indian or Alaska Native _____%
- e) Native Hawaiian or Pacific Islander _____%
- f) Asian American _____%
- g) Other _____%

6. Please describe any other general population characteristics, for example if the practice serves a large percentage of patients who are low-income; homeless; immigrants; pregnant women; children/adolescents; seniors; persons with mental illness; persons in treatment for substance abuse; or persons with disabilities; or other. _____

Tobacco Fax Referral Training session information:

Number of participants: _____ Dietary Restrictions: _____

Dates Available

Please identify your practice's availability for the one-hour lunchtime or breakfast session. Choose dates when *all members* of your practice can be present.

1. Preference #1: _____

2. Preference #2: _____

3. Preference #3: _____

Additional Information

Is there anything else we should know?

Please fax form to WMHD Tobacco Prevention & Control (801-399-7185) or print and mail to:

Weber-Morgan Health Department
Attn: Anna Guymon, Tobacco Program
477 23rd St.
Ogden, UT. 84401