Mom's Quit Connection
*Helping families live tobacco-free*

2500 McClellan Avenue, Suite 250
Pennsauken, New Jersey 08109

856.665.6000 / 856.665.7711 fax
888.545.5191 toll-free
www.snjpc.org

# Fax To

**Please fax this form to MQC, then place original on patient's chart.**

**Date:** _____

**To:** **Mom's Quit Connection Smoking Cessation Support Counselor**

**Phone:** **856-665-6000** **Fax:** **856-665-7711**

**From:** _____
*Provider Name*

_____
*Hospital/Office Name*

**Phone:** _____ **Fax:** _____

**Email:** _____

**# Pages including cover:** _____

**THIS SECTION TO BE COMPLETED BY CLIENT**

**CONSENT**

I have been informed about Mom's Quit Connection, a FREE smoking cessation service for pregnant women and new mothers. I give permission for an MQC counselor to contact me via phone, text, email or mail and tell me more about the program. I understand that by having someone contact me, I am under no obligation to sign up for services. I understand that this form will be faxed to the MQC office.

**PLEASE PRINT:**

First Name _____ Last Name _____

Street Address _____ Apt. No. _____

City _____ State _____ Zip Code _____County_____

Phone/Text (_____) _____ e-mail _____

Preferred call times _____
*Mom's Quit Connection operates M-F, 8:30 am-5:00 pm*

Date of Birth _____

Signature: _____

**STAGE OF REDINESS**

**Please check what best describes you:**

- ❑ Ready to quit
- ❑ Willing to talk about quitting
- ❑ **Want more information:**
  - ❑ About quitting
  - ❑ About second hand smoke

**Are you pregnant?**

- ❑ Yes Due Date: _____
- ❑ No

**Do you now have or have you ever had diabetes?**

- ❑ Yes
- ❑ No

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