Mom's Quit Connection®
*Quit smoking with support during and after pregnancy*

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 call me 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 _____

Phone Number (_____) _____ e-mail _____

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

Date of Birth _____

Signature: _____

## Stage of Readiness

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

 597/429