June 2007

Dr. _____:

Your patient, _____, is enrolled in the MGH Tobacco Treatment Service's upcoming smoking cessation group program. With approval of the patient's physician, we are able to provide low-cost nicotine replacement therapy (nicotine patch or gum) to patients who attend weekly counseling sessions.

Please let us know if this patient is medically approved to use NRT by filling out the form below and faxing it back to us as soon as possible.

If you have any questions, I can be reached at (617) 726-7443.

Thank you.

Karen Silva
Program Coordinator

Patient Name: _____

Date of Birth: _____

We are seeing your patient in the MGH Tobacco Treatment Service. Supplemental funding from the hospital allows us to provide low-cost nicotine replacement therapy (nicotine patch or gum) to patients attending our program.

We require approval from the patient's physician prior to starting nicotine replacement therapy. Please check below, sign and return this form to us.

☐ **Patient is medically approved to use nicotine patch gum, or lozenge.**
(No unstable angina, MI in past 2 weeks, serious arrhythmia or uncontrolled high blood pressure)

☐ **Patient is not approved to use nicotine patch, gum or lozenge.**

Provider Signature: _____ Location: _____

Provider Name (printed): _____ Date: _____

Please fax back to the MGH Tobacco Treatment Service: (617) 724-6774

Revised 10/06