Smoke-Free Pregnancy Program

Please fax completed referral form to: Community Cancer Center Attn: Angelia Freeman, 541-672-9483

Personal Information:

Name: ________________________________ Phone: ______________

Mailing Address: ________________________________ Zip code: ______________

Email: ________________________________ Date of Birth: ______________

Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Non-Binary ☐ Prefer not to respond

What is the highest grade of school that you have completed? ______________ Annual Household Income: ______________

Are you currently pregnant or are attempting to become pregnant? ______________ If so, what is your due date: ______________

Please select the race/ethnic identity, tribal affiliation, country of origin, or ancestry which best describes you:

☐ African American
☐ Asian | Pacific Islander
☐ Alaska Native
☐ Caucasian
☐ Cuban
☐ East Indian
☐ Hispanic | Latino | Mexican
☐ Native American
☐ Ethnoreligious
☐ Mixed
☐ Other
☐ Prefer not to respond

Tell Us About Your Nicotine Habit:

1. Do you currently smoke cigarettes, use chewing tobacco, or use nicotine delivery devices? ______________
2. How many cigarettes do you smoke each day? ______________
3. How many packs of cigarettes, vape cartridges, or cans of chewing tobacco do you smoke/use per week? ______________
4. When did you first start using tobacco products (age)? ______________
5. Approximately how long have you used nicotine and or tobacco products? __________ years __________ months
6. What form of tobacco products do you currently use? ______________
7. How many times have you attempted to quit in the past? ______________
8. How long was your longest quit attempt? ______________
9. Are there other smokers in your household? ______________
10. How do you rate your level of motivation to quit? ☐ Not motivated at all ☐ Somewhat motivated ☐ Very motivated

Signature: ________________________________ Date: ______________

Community Cancer Center   DOUGLAS PUBLIC HEALTH NETWORK   Thrive Umpqua