

## 3As + R

**Ask**  
**Advise**  
**Assess**  
**Refer**

### Ask

Ask patient about tobacco use status

### Advise

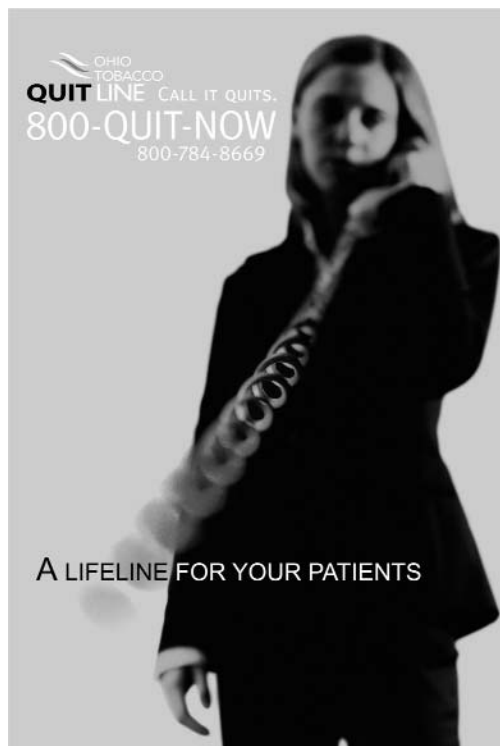
Provide clear, strong advice to quit with personalized messages about the impact of tobacco use

### Assess

Assess the willingness of the patient to make a quit attempt in the next 30 days

### Refer

Fax a signed referral form to the QUIT LINE with all required information



## READINESS TO QUIT

If the answer to one of the following questions is **YES**, then **REFER** your patient to the

### Ohio Tobacco QUIT LINE

- Do you intend to quit using tobacco within the next 30 days?
- If you've already quit, would you like support at this time?



## FAX AN OHIO TOBACCO QUIT LINE REFERRAL FORM TO 800-784-8669

■ TUPCF Grantee ID is **OUTREACH**

- Use your hospital's complete, official name as referring provider
- Have patient sign form for consent
- Have physician sign if nicotine replacement therapy is appropriate