Tobacco Cessation Action Plan

As part of my recent diagnosis, my physician has indicated that tobacco cessation is crucial to my successful treatment. I agree to the following plan indicated below by a check mark.

□ 1(800) QUIT-NOW (Call 1-800-784-8669 for free counseling from trained coaches)

□ "Get off Your Butt: Stay Smokeless for Life" at-home tobacco cessation program (visit www.wellnessforme.com to request a free program)

□ Telephonic health coaching through Web MD Health Services (*Optima Health members only* login on www.optimahealth.com)

□ Care Management (Call Member Services number on your health plan ID card)

□ Other (e.g. nicotine patch, gum, prescription medication; please specify below):
_______________________________________________________________________________

I will not use tobacco products after my "quit date" of ____________________________.

In the event that I cannot complete the plan as discussed and outlined above, I will call my health care provider to get a new plan in place.

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|---|---|
| _____________________________ | ______________________________ |
| Patient Name - Print | Patient Signature |
| ______________________________ | _______________________________ |
| Health Care Partner/Provider– Print Name | Health Care Partner/Provider Signature |