

FIRST QUIT CONSULTATION MEETING

Name: _____ Date: _____

Appointment location: _____

Where possible, the First Quit Consultation should be an in person meeting at the pharmacy. If in-person meeting is not possible, please indicate method of appointment:

In person Telephone Video-conferencing Email Other:

ASSESS	<p>Tobacco Use History: <input type="checkbox"/> Daily smoker <input type="checkbox"/> Occasional smoker</p> <p>Current use: Number of cigarettes per day _____ for _____ years</p> <p># of Pack-years: Years smoked _____ x Packs per day: _____ = _____ Pack-years</p> <p>How soon after waking is first cigarette? _____ minutes</p> <p>Where do you smoke most often: _____</p> <p>What time of day is smoking predominantly done: _____</p> <p>Days of week predominantly smoking: _____</p> <p>With whom do you smoke (alone or socially): _____</p> <p>Number of other household smokers: _____</p> <p>Work place smoking: <input type="checkbox"/> Yes / <input type="checkbox"/> No _____</p> <p>Are you a source of 2nd hand smoke for family & friends: <input type="checkbox"/> Yes / <input type="checkbox"/> No _____</p> <p>Number of previous attempts to quit (24 hrs or more of intentional stop): _____</p> <p>Duration of Past Quit Attempts: _____</p> <p>Previous methods used and reason for relapse, if applicable:</p> <p>a. Patch: _____</p> <p>b. Gum: _____</p> <p>c. Lozenge: _____</p> <p>c. Inhaler: _____</p> <p>d. Medication: _____</p> <p>e. "Cold Turkey": _____</p> <p>f. Hypnosis: _____</p> <p>g. Other: _____</p> <p>From the methods indicated above, which was associated with the best results to date (from your perspective, e.g. not based on what you've heard): _____</p> <p>What led you to relapse: <input type="checkbox"/> Withdrawal symptoms; <input type="checkbox"/> Negative mood; <input type="checkbox"/> Habit; <input type="checkbox"/> Being with other smokers; <input type="checkbox"/> Stress;</p> <p>Other: _____</p> <p>Do you drink (alcohol) when you smoke? <input type="checkbox"/> Yes / <input type="checkbox"/> No; Number of drinks per day: _____</p> <p>Do you drink coffee when you smoke <input type="checkbox"/> Yes / <input type="checkbox"/> No; Number of cups per day: _____</p> <p>Are you under the care of your primary physician for smoking cessation? <input type="checkbox"/> Yes / <input type="checkbox"/> No</p>
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*To be filed for documentation and auditing purposes: 2 years for audit under the ODB program
10 years as part of the patient health record*

ASSIST	Medication Related History: May attach print out or MedsCheck if available	
	Allergies / Intolerance to medications: _____	
	Concurrent medications: <input type="checkbox"/> Benzodiazepines; <input type="checkbox"/> Antipsychotic; <input type="checkbox"/> Antidepressants;	
	<input type="checkbox"/> Other: _____	
	<input type="checkbox"/> Chronic conditions and consequences of smoking: _____	
	Cardiac History: <input type="checkbox"/> High Blood Pressure; Blood Pressure: _____; <input type="checkbox"/> Arrhythmia; Heart Rate: _____;	
	<input type="checkbox"/> Heart Failure; <input type="checkbox"/> Hypercholesterolemia; <input type="checkbox"/> Other heart related: _____	
	<input type="checkbox"/> Diabetes: <input type="checkbox"/> Type 1 _____; <input type="checkbox"/> Type 2 _____;	
	Respiratory History: <input type="checkbox"/> Asthma; <input type="checkbox"/> COPD;	
	<input type="checkbox"/> Lung related problems: _____	
<input type="checkbox"/> Past Seizure history: _____		
<input type="checkbox"/> Cancer: _____		
<input type="checkbox"/> Hormone Replacement Therapy; <input type="checkbox"/> Oral contraceptives: _____		
<input type="checkbox"/> Alcohol Use: _____		
<input type="checkbox"/> Depression; <input type="checkbox"/> Anxiety; <input type="checkbox"/> Eating disorders; <input type="checkbox"/> Bipolar disease; <input type="checkbox"/> Schizophrenia;		
Smoking-related health symptoms: <input type="checkbox"/> Cough; <input type="checkbox"/> Wheeze; <input type="checkbox"/> Shortness of breath; <input type="checkbox"/> Distorted Smell/Taste		
Smoking triggers and strategies to overcome them		
Triggers:		Strategies to consider:
1.		<input type="checkbox"/> Set a quit date
		<input type="checkbox"/> Start an exercise program
2.		<input type="checkbox"/> Change diet/start healthy snacking
		<input type="checkbox"/> Take up a new hobby/activity
3.		<input type="checkbox"/> Get plenty of rest;
		<input type="checkbox"/> Learn to relax/meditate
4.		<input type="checkbox"/> Join a smoking cessation group forum
		<input type="checkbox"/> Use quit smoking help-lines
5.		<input type="checkbox"/> Get counselling
		<input type="checkbox"/> Seek help/support from family/friends
		<input type="checkbox"/> Spend more time with non-smokers
		<input type="checkbox"/> Drink lots of water/cut down on alcohol
		<input type="checkbox"/> Other (specify)
Quit date: _____		
Considering pharmacotherapy?		
<input type="checkbox"/> Nicotine Patch; <input type="checkbox"/> Nicotine Gum; <input type="checkbox"/> Nicotine Lozenge; <input type="checkbox"/> Nicotine Inhaler; <input type="checkbox"/> Bupropion; <input type="checkbox"/> Varenicline;		
<input type="checkbox"/> None; <input type="checkbox"/> Other _____		
Start date: _____ Dose: _____		
Advice regarding drug therapy for this patient: _____		
If experiencing adverse events, patient to contact: _____		
Other notes:		
Name of Pharmacist: _____		
Submit electronic claim using PIN 93899941 \$40 <i>(limit to one claim per year) To be filed for documentation and auditing purposes. A copy may be provided to the patient.</i>		

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My Quit Plan

Plan for Preparation to Quit Smoking		
Name:	Phone #:	Email:
Quit Date:		
Medication: (check all that apply)		
<input type="checkbox"/> Nicotine Patch Start Date: _____	<input type="checkbox"/> Nicotine Gum Start Date: _____	<input type="checkbox"/> Nicotine Inhaler Start Date: _____
<input type="checkbox"/> Nicotine Lozenge Start Date: _____	<input type="checkbox"/> Bupropion Start Date: _____	<input type="checkbox"/> Varenicline Start Date: _____
<input type="checkbox"/> Other Start Date: _____	<input type="checkbox"/> No medication Start Date: _____	
Preparing environment:		
Remove tobacco and smoking from:		
<input type="checkbox"/> Home	<input type="checkbox"/> Work area	<input type="checkbox"/> Automobile
		<input type="checkbox"/> Other _____
Possible challenges to anticipate:		
<input type="checkbox"/> Stress	<input type="checkbox"/> Other smokers	<input type="checkbox"/> Drinking alcohol
<input type="checkbox"/> Nicotine urges	<input type="checkbox"/> Smoking cues	<input type="checkbox"/> Availability of cigarettes
<input type="checkbox"/> Weight gain	<input type="checkbox"/> Other	<input type="checkbox"/> Other
Strategies to overcome these challenges:		
<input type="checkbox"/> Delay tactic	<input type="checkbox"/> Distraction strategies (e.g., walking)	
<input type="checkbox"/> Places to avoid	<input type="checkbox"/> Places to go (where smoking prohibited)	
<input type="checkbox"/> Use quit smoking help-lines	<input type="checkbox"/> Join a smoking cessation group forum	
<input type="checkbox"/> Exercise program	<input type="checkbox"/> Change diet/start healthy snacking	
<input type="checkbox"/> Take up a new hobby/activity	<input type="checkbox"/> Other	
Next appointment date:	Pharmacist's Name:	Pharmacist's contact information:

Pharmacists to provide a copy for patient use; and a copy to attach to the patient's pharmacy file.

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