FIFE PHARMACY

NHS Fife

COMMUNITY PHARMACY STOP SMOKING SERVICE

FOR OFFICE USE ONLY Pharmacy ID number/Contractor Code

TO BE COMPLETED BY THE CLIENT

Name:

Date of birth: / /19

Male ☐ Female ☐

If you are female, are you pregnant?
☐ YES ☐ NO ☐ UNKNOWN

WHICH OF THE FOLLOWING BEST DESCRIBES YOUR ETHNIC ORIGIN?

(choose one section from A – F, and then tick one box only within that section)

A - White

Scottish ☐
English ☐
Welsh ☐
Northern Irish ☐
British ☐
Irish ☐
Gypsy/Traveller ☐
Polish ☐
Any other ethnic group ☐
(please specify)

B - Mixed or multiple ethnic groups

Any mixed or multiple ethnic groups ☐
(please specify)

C - Asian, Asian Scottish or Asian British

Pakistani, Pakistani Scottish or Pakistani British ☐
Indian, Indian Scottish, Indian British ☐
Bangladeshi, Bangladeshi Scottish, Bangladeshi British ☐

Chinese, Chinese Scottish, Chinese British ☐
Other ☐
(please specify)

D – African, Caribbean, or Black

African, African Scottish, African British ☐

Caribbean, Caribbean Scottish, Caribbean British ☐
Black, Black Scottish, Black British ☐

Other ☐
(please specify)

E- Other Ethnic background Arab ☐ Other ☐ (please specify)

F- Not disclosed ☐

Do you receive free prescriptions? Yes ☐ No ☐ Unknown ☐

EMPLOYMENT STATUS (please tick one box)

☐ In paid employment
☐ Retired
☐ Full-time student
☐ Homemaker/full-time parent or carer
☐ Permanently sick or disabled
☐ Unemployed
☐ Other (please specify)
☐ Not known/missing

PERSONAL DETAILS

Address –	Home telephone-
	Mobile telephone-
Postcode-	E-mail address-

TOBACCO USE AND QUIT ATTEMPTS

On average how many cigarettes do you usually smoke per day?
☐ 10 or less
☐ 11 – 20
☐ 21 – 30
☐ More than 30
☐ unknown

How soon after waking do you usually smoke your first cigarette?
☐ Within 5 mins
☐ 6 – 30 mins
☐ 31 – 60 mins
☐ After 60 mins
☐ unknown

How many times have you tried to quit smoking in the past year?
☐ No quit attempt
☐ Once
☐ 2 or 3 times
☐ 4 or more times
☐ unknown

PLEASE SIGN THE CONFIDENTIALITY STATEMENT OVERLEAF

TO BE COMPLETED BY THE PHARMACIST

INTERVENTION DETAILS

Date referred to service:

Date of initial appointment:

Quit date:

INTERVENTION(S) USED

Product(s) used

☐ NRT only (single product) ☐ NRT only (more than 1 product) ☐ None

& weeks used:……..

Type of intervention (tick all that apply)

☐ One to one sessions ☐ Telephone support ☐ Other (please specify) _____

4 WEEK FOLLOW-UP

Was the client successfully contacted for 4 week follow up?

☐ Yes ☐ No (Client did not consent to follow up) ☐ No (Client lost to follow up) ☐ No (Client died) ☐ Unknown

Date follow up carried out:

Client withdrawn from service at time of follow up? ☐ Yes

Has the client smoked at all (even a puff) in the last 2 weeks? ☐ Yes ☐ No ☐ Unknown

CO reading confirms quit? ☐ Yes ☐ No ☐ CO reading not taken

Name of pharmacist:
Signature:

Contractor Code:

This form should be sent to (note:pharmacy to retain copy for audit purposes):

Pharmacy Stamp:

DWF: Smoking Cessation Administrator,
House 2, Lynebank Hospital, Dunfermline KY11 4UW
KL: Smoking Cessation Administrator, Randolph
Wemyss Memorial Hospital, Buckhaven. KY8 1HU
GNEF: Smoking Cessation Administrator,
Ladybank Clinic, Commercial Road, Ladybank KY15 7JS

SMOKING CESSATION SERVICE CONSENT

Please read and complete the following. Please ask if you would like any item to be explained. If you do not agree to any of the following, you are still entitled to receive treatment.

I am willing for my details to be kept on a confidential database and for anonymised information to be used to assess how the stop smoking programme is working. ☐ YES ☐ NO

I agree to be contacted in the future in connection with my smoking (at 4 weeks, 3 months and 12 months).
☐ YES ☐ NO

How would you prefer to be contacted: ☐ Phone ☐ Post ☐ Email

DATA CONFIDENTIALITY AND SECURITY (To be signed by the client)

The information provided by you will be held in a secure environment in accordance with The Data Protection Act 1998. The information will only be used to assess the outcome of this project and no details will be passed on to any organisations who are not involved in the outcome assessment.

Signature …….. Date ……../……/ 20……