

Pharmacy stamp/pharmacy name and address

**ON COMPLETION PLEASE SEND FORM TO:**

**Ann Buchanan**  
**Secretary to Chief Pharmacist Primary Care**  
**Strathclyde Hospital**  
**Airbles Road**  
**MOTHERWELL**  
**ML1 3BW**      **Secure Fax: 01698 245091**

**Pharmacy code**

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**Section A: Client Information**

<p>Title: _____</p> <p>Forename: _____</p> <p>Surname: _____</p> <p>Full address: _____</p> <p>Full postcode: _____</p> <p>Home telephone: _____</p> <p>Mobile telephone: _____</p> <p>Email: _____</p>	<p>Date of Birth: ___/___/___</p> <p>Gender:      Male: <input type="checkbox"/>      Female <input type="checkbox"/></p> <p>GP Name &amp; Practice: _____</p> <p>Referral source: _____</p> <p>Where did client hear about this service: _____</p> <p>Does client receive free prescriptions? Yes <input type="checkbox"/> No <input type="checkbox"/>      Unknown <input type="checkbox"/></p> <p>Is client pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>      Breastfeeding    Yes <input type="checkbox"/> No <input type="checkbox"/></p>
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**Employment status? (please tick one box)**

- |  |   |
|--|---|
| <input type="checkbox"/> In paid employment                  | <input type="checkbox"/> Full-time student            |
| <input type="checkbox"/> Homemaker/full-time parent or carer | <input type="checkbox"/> Unemployed                   |
| <input type="checkbox"/> Retired                             | <input type="checkbox"/> Permanently sick or disabled |
| <input type="checkbox"/> Not known/missing                   | <input type="checkbox"/> Other (please specify) _____ |

**Which of the following best describes the client's ethnic origin?**  
(Ask client to 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 white 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**

- Asian, Asian Scottish or Asian British
- Pakistani, Pakistani Scottish or Pakistani British
- Indian, Indian Scottish or Indian British Bangladeshi,
- Bangladeshi Scottish or Bangladeshi British
- Chinese, Chinese Scottish or Chinese British
- Other, please specify \_\_\_\_\_

**D. African, Caribbean or Black**

- African, Caribbean or Black
- African, African Scottish or African British
- Caribbean, Caribbean Scottish or Caribbean British Black, Black Scottish or Black British
- Other, please specify \_\_\_\_\_

- E. Other Ethnic background**    Arab     Other  Please specify \_\_\_\_\_    **F. Not Disclosed**

**Section B: Tobacco Use and Quit and Attempts**

How soon after waking does the client usually smoke their first cigarette?

- Within 5 minutes
- 6 - 30 minutes
- 31 – 60 minutes
- After 60 minutes
- Unknown

On average, how many cigarettes does the client usually smoke per day?

- 10 or less
- 11 – 20
- 21- 30
- More than 30
- Unknown

How many times has the client tried to quit smoking in the past year?

- No quit attempts
- Once
- 2 or 3 times
- 4 or more times
- Unknown

**Section C: Quit Date**

Referral date \_\_\_/\_\_\_/\_\_\_

Initial appointment date \_\_\_/\_\_\_/\_\_\_

Quit date \_\_\_/\_\_\_/\_\_\_

Can we text you? Yes  No

**Section D: Four week post quit date follow-up**

Was the client successfully contacted for four week follow-up?

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

Date follow-up carried out: \_\_\_/\_\_\_/\_\_\_ dd/mm/yy

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 (if applicable)?  Yes  No  CO reading not taken

Type of intervention (tick all that apply)

- One to One Sessions
- Telephone Support
- Other (please specify) \_\_\_\_\_

Products used

NRT only (single Product)  NRT (more than one product)  none Total number of weeks used \_\_\_\_\_

Name of pharmacist \_\_\_\_\_ Signature \_\_\_\_\_

**Section E: 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 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

**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 ...../...../.....