

| INITIAL DATA CAPTURE   |   |  |  |
|--|---|--|--|
| <b>Client Details</b>  |   |  |  |
| Does the client consent to follow up? <input checked="" type="checkbox"/> Yes  |   |  |  |
| CHI:   | First Name:   | Surname:   |  |
| Date of Birth: ___/___/___   | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female | Title:   |  |
| Address:   | Home Telephone:   |  |  |
|  | Mobile Telephone:   |  |  |
|  | Work Telephone:   |  |  |
| Postcode:  | Email Address   |  |  |
| If female, pregnant?   | <input type="checkbox"/> Yes <input type="checkbox"/> No              |  |  |
| <b>What is the clients ethnic group?</b>   |   |  |  |
| White  | <input type="checkbox"/> Scottish                                     | <input type="checkbox"/> Irish   | <input type="checkbox"/> Other British <input type="checkbox"/> Polish <input type="checkbox"/> Other <input type="checkbox"/> Gypsy Traveller |
| Asian  | <input type="checkbox"/> Asian Indian                                 | <input type="checkbox"/> Asian Pakistani   | <input type="checkbox"/> Asian Bangladeshi <input type="checkbox"/> Asian Chinese <input type="checkbox"/> Asian Other                         |
| Black  | <input type="checkbox"/> Black African                                | <input type="checkbox"/> Black Caribbean   | <input type="checkbox"/> Black Other <input type="checkbox"/> Other African <input type="checkbox"/> Arab                                      |
| Mixed (please specify):  | Other (please specify):   |  | <input type="checkbox"/> Not Disclosed   |
| <b>What is the clients Employment Status?</b>  |   |  |  |
| <input type="checkbox"/> In paid employment <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Full Time Student <input type="checkbox"/> Permanently Sick or Disabled<br><input type="checkbox"/> Homemaker/ Full time parent/ Carer <input type="checkbox"/> Other (please specify): <input type="checkbox"/> Not known/ Missing  |   |  |  |
| <b>Tobacco use and quit attempts</b>   |   |  |  |
| On average, how many cigarettes does the client usually smoke per day?   |   |  |  |
| <input type="checkbox"/> 10 or less <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-30 <input type="checkbox"/> More than 30 <input type="checkbox"/> Unknown   |   |  |  |
| How soon after waking up does the client usually smoke their first cigarette?  |   |  |  |
| <input type="checkbox"/> Within 5 minutes <input type="checkbox"/> 6-30 minutes <input type="checkbox"/> 31-60 minutes <input type="checkbox"/> After one hour <input type="checkbox"/> Unknown  |   |  |  |
| How many times has the client tried to quit smoking in the past year?  |   |  |  |
| <input type="checkbox"/> No quit attempts <input type="checkbox"/> Once <input type="checkbox"/> 2 or 3 times <input type="checkbox"/> 4 or more times <input type="checkbox"/> Unknown  |   |  |  |
| <b>Referral and assessment context</b>   |   |  |  |
| Date Referred to Service: ___/___/___  |   |  |  |
| <input type="checkbox"/> Self Referral <input type="checkbox"/> HealthPoint <input type="checkbox"/> Pharmacist <input type="checkbox"/> Smokeline<br><input type="checkbox"/> Dentist <input type="checkbox"/> Hospital <input type="checkbox"/> Practice Nurse <input type="checkbox"/> Prison<br><input type="checkbox"/> GP <input type="checkbox"/> Midwife <input type="checkbox"/> Stop Smoking Roadshow <input type="checkbox"/> Incentive Scheme<br><input type="checkbox"/> Health Visitor <input type="checkbox"/> Other (please specify) |   |  |  |
| Intervention Setting <input checked="" type="checkbox"/> Pharmacy  |   |  |  |
| Date of initial appointment: ___/___/___   |   |  |  |
| Intervention(s) used in this quit attempt <input checked="" type="checkbox"/> One to one sessions  |   |  |  |
| Shared care between pharmacy and non-pharmacy services? <input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |
| <b>Pharmaceutical usage (at week 0 may not yet be determined and can edited at week 1, but if varenicline to be used must select at week 0 so that risk assessment prompts appear)</b>   |   |  |  |
| <input type="checkbox"/> NRT only (single product) <input type="checkbox"/> NRT and Bupropion (change in product)<br><input type="checkbox"/> NRT only (but more than one NRT product) <input type="checkbox"/> NRT and Varenicline (change in product)<br><input type="checkbox"/> Varenicline only <input type="checkbox"/> Unknown<br><input type="checkbox"/> Bupropion only <input type="checkbox"/> None   |   |  |  |
| Total Number of weeks of known product use _____ (likely to be 0)  |   |  |  |
| <b>If varenicline to be supplied, a risk assessment must be completed prior to supply</b>  |   |  |  |
| Does assessment indicate that the patient's GP should be contacted to confirm appropriateness? <input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |
| I confirm that I am aware the GP must be informed that the patient will begin on varenicline <input checked="" type="checkbox"/>   |   |  |  |
| Quit Date  | ___/___/___   | Do not set at wk. 0, wait until actual quit starts i.e. wk. 1 – because follow-up/MDS prompts are calculated from the actual quit date. MDS will only be sent once quit date confirmed – triggers remuneration |  |

| CONTACT RECORDS WEEKS 1-4 |  |   |    | Product/Contact Notes:  |  |
|---------------------------|--|---|----|---|--|
| Date                      | Contact Type   | Smoked?   | CO | Product   |  |
| 1                         | <input type="checkbox"/> Face to Face <input type="checkbox"/> Text<br><input type="checkbox"/> Telephone <input type="checkbox"/> Email | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |    | <input type="checkbox"/> 16 hr patch <input type="checkbox"/> 24 hr patch <input type="checkbox"/> Lozenge <input type="checkbox"/> Sub-Lingual tablet<br><input type="checkbox"/> Gum <input type="checkbox"/> Nasal Spray <input type="checkbox"/> Inhalator <input type="checkbox"/> Varenicline |  |
| 2                         | <input type="checkbox"/> Face to Face <input type="checkbox"/> Text<br><input type="checkbox"/> Telephone <input type="checkbox"/> Email | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |    | <input type="checkbox"/> 16 hr patch <input type="checkbox"/> 24 hr patch <input type="checkbox"/> Lozenge <input type="checkbox"/> Sub-Lingual tablet<br><input type="checkbox"/> Gum <input type="checkbox"/> Nasal Spray <input type="checkbox"/> Inhalator <input type="checkbox"/> Varenicline |  |
| 3                         | <input type="checkbox"/> Face to Face <input type="checkbox"/> Text<br><input type="checkbox"/> Telephone <input type="checkbox"/> Email | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |    | <input type="checkbox"/> 16 hr patch <input type="checkbox"/> 24 hr patch <input type="checkbox"/> Lozenge <input type="checkbox"/> Sub-Lingual tablet<br><input type="checkbox"/> Gum <input type="checkbox"/> Nasal Spray <input type="checkbox"/> Inhalator <input type="checkbox"/> Varenicline |  |
| 4                         | <input type="checkbox"/> Face to Face <input type="checkbox"/> Text<br><input type="checkbox"/> Telephone <input type="checkbox"/> Email | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |    | <input type="checkbox"/> 16 hr patch <input type="checkbox"/> 24 hr patch <input type="checkbox"/> Lozenge <input type="checkbox"/> Sub-Lingual tablet<br><input type="checkbox"/> Gum <input type="checkbox"/> Nasal Spray <input type="checkbox"/> Inhalator <input type="checkbox"/> Varenicline |  |

**4 WEEK MDS SUBMISSION**

Was client successfully contacted for 1-month follow up?  Yes  No  No  
 Date follow up carried out: \_\_\_/\_\_\_/\_\_\_

Client withdrawn from service at time of follow up?  Yes  No  CO Not Taken

Has client smoked at all (even a puff) in the last 2 weeks?  Yes  No  
 CO reading confirms quit?  Yes  No  CO Not Taken

Reason CO reading not taken?  Patient declined  Equipment not available  Follow up not in person

| CONTACT RECORDS WEEKS 5-12 |  |   |    | Product/Contact Notes:  |  |
|----------------------------|--|---|----|---|--|
| Date                       | Contact Type   | Smoked?   | CO | Product   |  |
| 5                          | <input type="checkbox"/> Face to Face <input type="checkbox"/> Text<br><input type="checkbox"/> Telephone <input type="checkbox"/> Email | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |    | <input type="checkbox"/> 16 hr patch <input type="checkbox"/> 24 hr patch <input type="checkbox"/> Lozenge <input type="checkbox"/> Sub-Lingual tablet<br><input type="checkbox"/> Gum <input type="checkbox"/> Nasal Spray <input type="checkbox"/> Inhalator <input type="checkbox"/> Varenicline |  |
| 6                          | <input type="checkbox"/> Face to Face <input type="checkbox"/> Text<br><input type="checkbox"/> Telephone <input type="checkbox"/> Email | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |    | <input type="checkbox"/> 16 hr patch <input type="checkbox"/> 24 hr patch <input type="checkbox"/> Lozenge <input type="checkbox"/> Sub-Lingual tablet<br><input type="checkbox"/> Gum <input type="checkbox"/> Nasal Spray <input type="checkbox"/> Inhalator <input type="checkbox"/> Varenicline |  |
| 7                          | <input type="checkbox"/> Face to Face <input type="checkbox"/> Text<br><input type="checkbox"/> Telephone <input type="checkbox"/> Email | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |    | <input type="checkbox"/> 16 hr patch <input type="checkbox"/> 24 hr patch <input type="checkbox"/> Lozenge <input type="checkbox"/> Sub-Lingual tablet<br><input type="checkbox"/> Gum <input type="checkbox"/> Nasal Spray <input type="checkbox"/> Inhalator <input type="checkbox"/> Varenicline |  |
| 8                          | <input type="checkbox"/> Face to Face <input type="checkbox"/> Text<br><input type="checkbox"/> Telephone <input type="checkbox"/> Email | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |    | <input type="checkbox"/> 16 hr patch <input type="checkbox"/> 24 hr patch <input type="checkbox"/> Lozenge <input type="checkbox"/> Sub-Lingual tablet<br><input type="checkbox"/> Gum <input type="checkbox"/> Nasal Spray <input type="checkbox"/> Inhalator <input type="checkbox"/> Varenicline |  |
| 9                          | <input type="checkbox"/> Face to Face <input type="checkbox"/> Text<br><input type="checkbox"/> Telephone <input type="checkbox"/> Email | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |    | <input type="checkbox"/> 16 hr patch <input type="checkbox"/> 24 hr patch <input type="checkbox"/> Lozenge <input type="checkbox"/> Sub-Lingual tablet<br><input type="checkbox"/> Gum <input type="checkbox"/> Nasal Spray <input type="checkbox"/> Inhalator <input type="checkbox"/> Varenicline |  |
| 10                         | <input type="checkbox"/> Face to Face <input type="checkbox"/> Text<br><input type="checkbox"/> Telephone <input type="checkbox"/> Email | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |    | <input type="checkbox"/> 16 hr patch <input type="checkbox"/> 24 hr patch <input type="checkbox"/> Lozenge <input type="checkbox"/> Sub-Lingual tablet<br><input type="checkbox"/> Gum <input type="checkbox"/> Nasal Spray <input type="checkbox"/> Inhalator <input type="checkbox"/> Varenicline |  |
| 11                         | <input type="checkbox"/> Face to Face <input type="checkbox"/> Text<br><input type="checkbox"/> Telephone <input type="checkbox"/> Email | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |    | <input type="checkbox"/> 16 hr patch <input type="checkbox"/> 24 hr patch <input type="checkbox"/> Lozenge <input type="checkbox"/> Sub-Lingual tablet<br><input type="checkbox"/> Gum <input type="checkbox"/> Nasal Spray <input type="checkbox"/> Inhalator <input type="checkbox"/> Varenicline |  |
| 12                         | <input type="checkbox"/> Face to Face <input type="checkbox"/> Text<br><input type="checkbox"/> Telephone <input type="checkbox"/> Email | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |    | <input type="checkbox"/> 16 hr patch <input type="checkbox"/> 24 hr patch <input type="checkbox"/> Lozenge <input type="checkbox"/> Sub-Lingual tablet<br><input type="checkbox"/> Gum <input type="checkbox"/> Nasal Spray <input type="checkbox"/> Inhalator <input type="checkbox"/> Varenicline |  |

**12 WEEK MDS SUBMISSION**

Was client successfully contacted for 3-month follow up?  Yes  No  CO Not Taken  
 Date follow up carried out: \_\_\_/\_\_\_/\_\_\_

Has client smoked at all since 1 month follow up?  Yes  No  
 Reason CO reading not taken?  Patient declined  Equipment not available  Follow up not in person

CO reading confirms quit?  Yes  No  CO Not Taken