Smoking Cessation Support Tool

INITIAL DATA CAPTURE		
Client Details		
Does the client consent to follow up? ☑ Yes		
CHI:	First Name:	Surname:
Date of Birth: ___ /___ /___	Gender: ☐ Male ☐ Female	Title:
Address:	Home Telephone:	
	Mobile Telephone:	
	Work Telephone:	required for follow-up
Postcode:	Email Address	
If female, pregnant?	☐ Yes ☐ No	

What is the clients ethnic group?						
White	☐ Scottish	☐ Irish	☐ Other British	☐ Polish	☐ Other	☐ Gypsy Traveller
Asian	☐ Asian Indian	☐ Asian Pakistani	☐ Asian Bangladeshi	☐ Asian Chinese	☐ Asian Other	
Black	☐ Black African	☐ Black Caribbean	☐ Black Other	☐ Other African		☐ Arab
Mixed (please specify):		Other (please specify):				☐ Not Disclosed

What is the clients Employment Status?

☐ In paid employment ☐ Unemployed ☐ Retired ☐ Full Time Student ☐ Permanently Sick or Disabled
☐ Homemaker/ Full time parent/ Carer Other (please specify): ☐ Not known/ Missing

Tobacco use and quit attempts

On average, how many cigarettes does the client usually smoke per day?
☐ 10 or less ☐ 11-20 ☐ 21-30 ☐ More than 30 ☐ Unknown

How soon after waking up does the client usually smoke their first cigarette?
☐ Within 5 minutes ☐ 6-30 minutes ☐ 31-60 minutes ☐ After one hour ☐ 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

Referral and assessment context

Date Referred to Service:: ___ /___ /___

☐ Self Referral	☐ HealthPoint	☐ Pharmacist	☐ Smokeline
☐ Dentist	☐ Hospital	☐ Practice Nurse	☐ Prison
☐ GP	☐ Midwife	☐ Stop Smoking Roadshow	☐ Incentive Scheme
☐ Health Visitor	☐ Other (please specify)		

Intervention Setting ☑ Pharmacy

Date of initial appointment: ___ /___ /___

Intervention(s) used in this quit attempt) ☑ One to one sessions

Shared care between pharmacy and non-pharmacy services? ☐ Yes ☐ No

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)*

☐ NRT only (single product)	☐ NRT and Buproprion (change in product)
☐ NRT only (but more than one NRT product)	☐ NRT and Varenicline (change in product)
☐ Varenicline only	☐ Unknown
☐ Buproprion only	☐ None

Total Number of weeks of known product use _____ (likely to be 0)

If varenicline to be supplied, a risk assessment must be completed prior to supply

Does assessment indicate that the patient's GP should be contacted to confirm appropriateness? ☐ Yes ☐ No

I confirm that I am aware the GP must be informed that the patient will begin on varenicline ☑

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						
	Date	Contact Type	Smoked?	CO	Product	Product/Contact Notes:
1		☐ Face to Face ☐ Text ☐ Telephone ☐ Email	☐ Yes ☐ No		☐ 16 hr patch ☐ 24 hr patch ☐ Lozenge ☐ Sub-Lingual tablet ☐ Gum ☐ Nasal Spray ☐ Inhalator ☐ Varenicline	
2		☐ Face to Face ☐ Text ☐ Telephone ☐ Email	☐ Yes ☐ No		☐ 16 hr patch ☐ 24 hr patch ☐ Lozenge ☐ Sub-Lingual tablet ☐ Gum ☐ Nasal Spray ☐ Inhalator ☐ Varenicline	
3		☐ Face to Face ☐ Text ☐ Telephone ☐ Email	☐ Yes ☐ No		☐ 16 hr patch ☐ 24 hr patch ☐ Lozenge ☐ Sub-Lingual tablet ☐ Gum ☐ Nasal Spray ☐ Inhalator ☐ Varenicline	
4		☐ Face to Face ☐ Text ☐ Telephone ☐ Email	☐ Yes ☐ No		☐ 16 hr patch ☐ 24 hr patch ☐ Lozenge ☐ Sub-Lingual tablet ☐ Gum ☐ Nasal Spray ☐ Inhalator ☐ Varenicline	

4 WEEK MDS SUBMISSION		
Was client successfully contacted for 1-month follow up? ☐ Yes ☐ No	Date follow up carried out: ____ /____ /____	Client withdrawn from service at time of follow up? ☐ Yes ☐ No
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						
	Date	Contact Type	Smoked?	CO	Product	Product/Contact Notes:
5		☐ Face to Face ☐ Text ☐ Telephone ☐ Email	☐ Yes ☐ No		☐ 16 hr patch ☐ 24 hr patch ☐ Lozenge ☐ Sub-Lingual tablet ☐ Gum ☐ Nasal Spray ☐ Inhalator ☐ Varenicline	
6		☐ Face to Face ☐ Text ☐ Telephone ☐ Email	☐ Yes ☐ No		☐ 16 hr patch ☐ 24 hr patch ☐ Lozenge ☐ Sub-Lingual tablet ☐ Gum ☐ Nasal Spray ☐ Inhalator ☐ Varenicline	
7		☐ Face to Face ☐ Text ☐ Telephone ☐ Email	☐ Yes ☐ No		☐ 16 hr patch ☐ 24 hr patch ☐ Lozenge ☐ Sub-Lingual tablet ☐ Gum ☐ Nasal Spray ☐ Inhalator ☐ Varenicline	
8		☐ Face to Face ☐ Text ☐ Telephone ☐ Email	☐ Yes ☐ No		☐ 16 hr patch ☐ 24 hr patch ☐ Lozenge ☐ Sub-Lingual tablet ☐ Gum ☐ Nasal Spray ☐ Inhalator ☐ Varenicline	
9		☐ Face to Face ☐ Text ☐ Telephone ☐ Email	☐ Yes ☐ No		☐ 16 hr patch ☐ 24 hr patch ☐ Lozenge ☐ Sub-Lingual tablet ☐ Gum ☐ Nasal Spray ☐ Inhalator ☐ Varenicline	
10		☐ Face to Face ☐ Text ☐ Telephone ☐ Email	☐ Yes ☐ No		☐ 16 hr patch ☐ 24 hr patch ☐ Lozenge ☐ Sub-Lingual tablet ☐ Gum ☐ Nasal Spray ☐ Inhalator ☐ Varenicline	
11		☐ Face to Face ☐ Text ☐ Telephone ☐ Email	☐ Yes ☐ No		☐ 16 hr patch ☐ 24 hr patch ☐ Lozenge ☐ Sub-Lingual tablet ☐ Gum ☐ Nasal Spray ☐ Inhalator ☐ Varenicline	
12		☐ Face to Face ☐ Text ☐ Telephone ☐ Email	☐ Yes ☐ No		☐ 16 hr patch ☐ 24 hr patch ☐ Lozenge ☐ Sub-Lingual tablet ☐ Gum ☐ Nasal Spray ☐ Inhalator ☐ Varenicline	

12 WEEK MDS SUBMISSION		
Was client successfully contacted for 3-month follow up? ☐ Yes ☐ No	Date follow up carried out: ____ /____ /____	Has client smoked at all since 1 month follow up? ☐ 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	