|  |  |
| --- | --- |
| Client Name:  | Address:   Post code:  |
| Quit Date:  | CHI:  |
| GP Practice:  | Pharmacy:   |

The above named client had an appointment on date. and has been assessed by one of our practitioners. They have requested to use Nicotine Replacement Therapy in their quit attempt. We have assessed this patient’s suitability for the indicated product (s).

Please use the UCF to claim reimbursement for products supplied to the client.

**Please do not enter this client on PCR. The Quit Your Way team will enter the client on the National Smoking Cessation Database.**

 **NRT Request**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PRODUCT** | **First line product****Strength/Dosage** | **Pack Size** | **Quantity** | **Dispensing instructions** |
| Which product?  | Strength | Pack size | Quantity | In full |
| Which product?  | Strength | Pack size | Quantity | In full |
| Which product?  | Strength | Pack size | Quantity | In full |

**Additional information to be included:**

Thank you for your support.

Tobacco Control Practitioner: Choose an item. Mobile Number: Choose an item.

Pp:Choose an item.(Business Support Assistant) Date Requested: date.