Pharmacy Stamp

|  |  |
| --- | --- |
| Client name: |  |
| Address: |  |
|  |  |
| Telephone number: |  |
| Date of birth: |  |
| GPs name & address: |  |
|  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Factor** | **Yes** | **No** | **Notes** |
| Is client under 18 years of age |  |  | If ‘ yes’ – discuss NRT or refer to QYW team |
| Is client pregnant or breastfeeding? |  |  | If ‘ yes’ – discuss NRT or refer to QYW team |
| Does client have known severe renal impairment? |  |  | If ‘ yes’- Varenicline not suitable and discuss NRT |
| Does client suffer from epilepsy? |  |  | If ‘ yes’ – Varenicline not suitable and discuss NRT |
| Is client currently on another smoking cessation therapy? |  |  | If ‘ yes’ – advise stopping that product before supplying varenicline |
| Is client on clozapine? |  |  | If ‘yes’-Varenicline not suitable and discuss NRT |
| Is client hypersensitive to varenicline or any of its excipients? |  |  | If ‘ yes’ – discuss NRT |

**Special circumstances and any other relevant notes:**

Clients should be advised to discontinue treatment and seek prompt medical advice if they develop agitation, depressed mood or suicidal thoughts. Patients with a history of psychiatric illness should be monitored closely while taking Varenicline.

|  |
| --- |
| **Action taken:**  Supply:  Referral to:  Advice given: |

The above information is correct to the best of my knowledge. I have been counselled on the use of varenicline and understand the advice given to me by the pharmacist.

**Client’s signature:**

Date

The action specified was based on the information given to me by the client, which to the best of my knowledge is correct.

**Pharmacist’s signature:**

Date