Pharmacy Stamp

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

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| --- | --- | --- | --- |
| **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.

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| **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