

Smoking Cessation Support Tool

INITIAL DATA CAPTURE		
Client Details		
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	
What is the clients ethnic group?		
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
What is the clients Employment Status?		
<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 <input type="checkbox"/> Homemaker/ Full time parent/ Carer <input type="checkbox"/> Other (please specify): <input type="checkbox"/> Not known/ Missing		
Tobacco use and quit attempts		
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		
Referral and assessment context		
Date Referred to Service: ___/___/___		
<input type="checkbox"/> Self Referral <input type="checkbox"/> HealthPoint <input type="checkbox"/> Pharmacist <input type="checkbox"/> Smokeline <input type="checkbox"/> Dentist <input type="checkbox"/> Hospital <input type="checkbox"/> Practice Nurse <input type="checkbox"/> Prison <input type="checkbox"/> GP <input type="checkbox"/> Midwife <input type="checkbox"/> Stop Smoking Roadshow <input type="checkbox"/> Incentive Scheme <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		
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)		
<input type="checkbox"/> NRT only (single product) <input type="checkbox"/> NRT and Bupropion (change in product) <input type="checkbox"/> NRT only (but more than one NRT product) <input type="checkbox"/> NRT and Varenicline (change in product) <input type="checkbox"/> Varenicline only <input type="checkbox"/> Unknown <input type="checkbox"/> Bupropion only <input type="checkbox"/> 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? <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	___/___/___	<i>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</i>

CONTACT RECORDS WEEKS 1-4						
	Date	Contact Type	Smoked?	CO	Product	Product/Contact Notes: Hints and Tips
1		<input type="checkbox"/> Face to Face <input type="checkbox"/> Text <input type="checkbox"/> Telephone <input type="checkbox"/> Email	<input type="checkbox"/> Yes <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 <input type="checkbox"/> Gum <input type="checkbox"/> Nasal Spray <input type="checkbox"/> Inhalator <input type="checkbox"/> Varenicline	Focus on getting ready for Quit Date: Anticipate problems: Keep busy!
2		<input type="checkbox"/> Face to Face <input type="checkbox"/> Text <input type="checkbox"/> Telephone <input type="checkbox"/> Email	<input type="checkbox"/> Yes <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 <input type="checkbox"/> Gum <input type="checkbox"/> Nasal Spray <input type="checkbox"/> Inhalator <input type="checkbox"/> Varenicline	Take it a day at a time : Use your support systems: Change your Routine!
3		<input type="checkbox"/> Face to Face <input type="checkbox"/> Text <input type="checkbox"/> Telephone <input type="checkbox"/> Email	<input type="checkbox"/> Yes <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 <input type="checkbox"/> Gum <input type="checkbox"/> Nasal Spray <input type="checkbox"/> Inhalator <input type="checkbox"/> Varenicline	Find things to do with your hands : Think of your Motivator!
4		<input type="checkbox"/> Face to Face <input type="checkbox"/> Text <input type="checkbox"/> Telephone <input type="checkbox"/> Email	<input type="checkbox"/> Yes <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 <input type="checkbox"/> Gum <input type="checkbox"/> Nasal Spray <input type="checkbox"/> Inhalator <input type="checkbox"/> Varenicline	Drink cold water or juice, it helps!: Just one more week!

4 WEEK MDS SUBMISSION		
Was client successfully contacted for 1-month follow up?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date follow up carried out: ___/___/___
Client withdrawn from service at time of follow up?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Has client smoked at all (even a puff) in the last 2 weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No	CO reading confirms quit? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CO Not Taken
Reason CO reading not taken?	<input type="checkbox"/> Patient declined <input type="checkbox"/> Equipment not available <input type="checkbox"/> Follow up not in person	

CONTACT RECORDS WEEKS 5-12						
	Date	Contact Type	Smoked?	CO	Product	Product/Contact Notes:
5		<input type="checkbox"/> Face to Face <input type="checkbox"/> Text <input type="checkbox"/> Telephone <input type="checkbox"/> Email	<input type="checkbox"/> Yes <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 <input type="checkbox"/> Gum <input type="checkbox"/> Nasal Spray <input type="checkbox"/> Inhalator <input type="checkbox"/> Varenicline	Remember 4 week Follow Up; Well Done! One Month Quit! Give Certificate
6		<input type="checkbox"/> Face to Face <input type="checkbox"/> Text <input type="checkbox"/> Telephone <input type="checkbox"/> Email	<input type="checkbox"/> Yes <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 <input type="checkbox"/> Gum <input type="checkbox"/> Nasal Spray <input type="checkbox"/> Inhalator <input type="checkbox"/> Varenicline	Think of your Motivator and how much you have saved!!!
7		<input type="checkbox"/> Face to Face <input type="checkbox"/> Text <input type="checkbox"/> Telephone <input type="checkbox"/> Email	<input type="checkbox"/> Yes <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 <input type="checkbox"/> Gum <input type="checkbox"/> Nasal Spray <input type="checkbox"/> Inhalator <input type="checkbox"/> Varenicline	Deep Breathing helps: Look for distractions!
8		<input type="checkbox"/> Face to Face <input type="checkbox"/> Text <input type="checkbox"/> Telephone <input type="checkbox"/> Email	<input type="checkbox"/> Yes <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 <input type="checkbox"/> Gum <input type="checkbox"/> Nasal Spray <input type="checkbox"/> Inhalator <input type="checkbox"/> Varenicline	Keep Busy: Don't let temptation get a grip: Don't Smoke!!!
9		<input type="checkbox"/> Face to Face <input type="checkbox"/> Text <input type="checkbox"/> Telephone <input type="checkbox"/> Email	<input type="checkbox"/> Yes <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 <input type="checkbox"/> Gum <input type="checkbox"/> Nasal Spray <input type="checkbox"/> Inhalator <input type="checkbox"/> Varenicline	You are doing well! keep Going! Don't Weaken!
10		<input type="checkbox"/> Face to Face <input type="checkbox"/> Text <input type="checkbox"/> Telephone <input type="checkbox"/> Email	<input type="checkbox"/> Yes <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 <input type="checkbox"/> Gum <input type="checkbox"/> Nasal Spray <input type="checkbox"/> Inhalator <input type="checkbox"/> Varenicline	Only a few weeks to go: Will you cope? If unsure prepare for beyond the 12 weeks
11		<input type="checkbox"/> Face to Face <input type="checkbox"/> Text <input type="checkbox"/> Telephone <input type="checkbox"/> Email	<input type="checkbox"/> Yes <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 <input type="checkbox"/> Gum <input type="checkbox"/> Nasal Spray <input type="checkbox"/> Inhalator <input type="checkbox"/> Varenicline	You will be fine: Keep Going you're nearly there!!
12		<input type="checkbox"/> Face to Face <input type="checkbox"/> Text <input type="checkbox"/> Telephone <input type="checkbox"/> Email	<input type="checkbox"/> Yes <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 <input type="checkbox"/> Gum <input type="checkbox"/> Nasal Spray <input type="checkbox"/> Inhalator <input type="checkbox"/> Varenicline	At Last! Well Done! Give Certificate: Do You need further Support?

12 WEEK MDS SUBMISSION		
Was client successfully contacted for 3-month follow up?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date follow up carried out: ___/___/___
Has client smoked at all since 1 month follow up?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
CO reading confirms quit?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CO Not Taken	Reason CO reading not taken? <input type="checkbox"/> Patient declined <input type="checkbox"/> Equipment not available <input type="checkbox"/> Follow up not in person