**Tobacco Cessation Program: Final Contact Form**

Insert your pharmacy logo here

This document should be completed by the pharmacist at the anticipated end of each patient’s medication regimen.

The contact can be made in person or via telephone.

**Date: Time: Pharmacist’s name:**

**Section 1: Patient information**

**Name (Last, First):**  **Date of birth:**

**Quit date:**

**Section 2: Cessation outcomes**

\_\_\_ Patient has successfully quit

\_\_\_ Patient quit but relapsed

 Duration of quit attempt:

 Reason(s) for relapse:

\_\_\_ Patient did not attempt to quit (did not stay off of tobacco for more than 24 hours)

\_\_\_ Patient is unable to be reached

 Date of contact attempt #1:

 Date of contact attempt #2:

**Section 3: Quitting strategies used**

**Behavioral: [Check all that apply]**

\_\_\_ Tobacco Quitline (1-800-QUIT NOW)

\_\_\_ Group or web-based program

\_\_\_ Behavioral counseling at the pharmacy

\_\_\_ Other:

\_\_\_ None

Does the patient feel he/she received sufficient help/support? (describe)

**Medication: [Check one]**

\_\_\_ No medication was provided

\_\_\_ Patient completed full duration of therapy

\_\_\_ Patient completed partial course of therapy

* Duration:
* Challenges:
* Other:

*Continued on back*

* **Did the patient experience any adverse effects due to the medication(s)?** **No Yes** *[If Yes, describe below]*
* **Were the patient’s withdrawal symptoms adequately managed?** **No** **Yes** *[If No, describe below]*
* **Plans for terminating the medication(s):**

**Section 4: Future plans**

\_\_\_ For tobacco-free patients: Prevent relapse

\_\_\_ For relapsed patients willing to try again: Initiate a new quit attempt

\_\_\_ For relapsed patients not willing to try again: Establish future resources for when they are ready

**Notes:**

**Section 5: Patient questions and concerns**

\_\_\_ None noted

\_\_\_ Questions/concerns discussed: *[Describe below]*