**Tobacco Cessation Program: Initial Follow-Up Form**

Insert your pharmacy logo here

(recommended within 14 days after the quit date)

**Date: Time: Pharmacist’s name:**

**Section 1: Patient information**

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

**Quit date:**

**Section 2: Behavioral assistance**

\_\_\_ Patient is enrolled with the Tobacco Quitline (1-800-QUIT NOW)

\_\_\_ Patient is participating in a group or web-based program

\_\_\_ Patient is receiving behavioral counseling at the pharmacy

\_\_\_ Other:

Does the patient feel he/she is getting sufficient help/support?

What coping challenges have they had since the quit date? Cravings?

**Section 3: Medication use**

* **Cessation medication(s) (name, strength) currently being used:**
* **Date medication(s) were initiated:**
* **Are the medication(s) being taken correctly?** **Yes** **No** *[describe below]*
* **Is the patient experiencing any adverse effects due to the medication(s)?** **Yes No** *[describe below]*
* **Are the patient’s withdrawal symptoms being managed?** **Yes** **No** *[describe below]*
* **Plans for terminating the medication(s):**

**Section 4: Interventions**

*Continued on back*

**Describe what is working as well as any changes that are recommended.**

|  |  |
| --- | --- |
| **1** | **Medication regimen:** |
| **2** | **Behavioral assistance recommendations:** |

**Section 5: Patient questions and concerns**

**Documentation**

**Complete the following and initial to the left of each requirement.**

\_\_\_ Discussed current medication use and modified regimen, if appropriate

\_\_\_ Discussed behavioral assistance and modified recommendations, if appropriate

\_\_\_ Documented ongoing treatment plan

\_\_\_ Discussed plans for termination of medications

\_\_\_ Notified patient that you will contact them at the *end* of their medication regimen

**Date:**

**ASK:** Confirm preferred contact #

\_\_\_ Remind patient to follow-up with PCP at their next visit