**Tobacco Cessation Program: Patient Intake Form**

Insert your pharmacy logo here

**Date: Time: Pharmacist’s name:**

**Section 1: Patient information**

**Name (Last, First):**  **Date of birth (must be 18+): Gender:**

**Primary phone number:** **Home address:**

**Insurance provider:**

|  |  |  |  |
| --- | --- | --- | --- |
| **BIN** | **PCN** | **Cardholder ID** | **Group number** |
|  |  |  |  |

**PCP name:**  **PCP phone number:**

**Section 2: Medical conditions**

|  |  |
| --- | --- |
| **Current medical conditions:** | **Past medical conditions:** |
| **1** | **1** |
| **2** | **2** |
| **3** | **3** |
| **4** | **4** |
| **5** | **5** |

**Section 3: High-risk screening**

|  |  |  |
| --- | --- | --- |
| **1** | Pregnant or planning to become pregnant in the next 6 months? | **No Yes** |
| **2** | Heart attack in past 2 weeks? | **No Yes** |
| **3** | History of arrhythmias or irregular heartbeat? | **No Yes**  IF YES, consult with or refer patient to PCP. |
| **4** | Unstable angina or chest pain with strenuous activity? | **No Yes** |
| **5** | History of mental health disorder and is perceived to not be stable? | **No Yes** |

**Section 4: Other history**

|  |  |  |
| --- | --- | --- |
| **1** | Family history of tobacco use or tobacco-related disease |  |
| **2** | Other medical conditions |  |
| **3** | Current living environment |  |
| **4** | Social history |  |

**Section 5: Medications and allergies/hypersensitivities**

**Current medications:**

**Allergies/hypersensitivities:**

*Continued on back*

**Section 6: Assess Tobacco Use History**

**ASK:** Are you ready to set a quit date? **N Y** (if yes, record quit date below under “Documentation”)

**ASK:** What types of tobacco / nicotine do you use?

|  |  |  |
| --- | --- | --- |
| Type | How much and how often (per day)? | How long used? |
| Cigarettes |  |  |
| E-cigarettes/JUUL/vaping |  |  |
| Smokeless tobacco (dip, chew) |  |  |
| Cigars or cigarillos |  |  |
| Other: |  |  |

**ASK:** How many minutes after you wake up do you have your first cigarette/tobacco/nicotine?

**ASK:** Any recent changes in your tobacco/nicotine use?

**ASK:** Have you tried to quit before? **Y N**

* **If YES:** How many times? When was last quit attempt? Longest quit attempt?

**ASK:** Did you call the tobacco quitline or participate in any other form of counseling? **Y N**

* **If YES:** What did you like, or not like, about it?

**ASK:** What quitting medicines have you tried in the past? Discuss effectiveness, withdrawal symptoms, how med was taken (daily and duration), overall experience (does it make sense to try it again?).

**ASK:** Main reasons for returning smoking/tobacco use? Anticipated challenges this time?

**Documentation**

**IF READY TO SET QUIT DATE,** complete the following and initial to the left of each requirement.

\_\_\_ Discuss medication options and select treatment

\_\_\_ Ask patient to choose a quit date (if using bupropion SR or varenicline, consider medication start date)

**Patient’s planned quit date is:**

\_\_\_ Refer patient to Tobacco Quitline (1-800-QUIT NOW) or other program:

\_\_\_ Document treatment plan

\_\_\_ Schedule follow-up appointment within 2 weeks of quit date:

**Date and time:**

**Circle one: In-person** or **Telephone ASK:** Confirm preferred contact #

\_\_\_ Advise patient to follow-up with PCP

\_\_\_ Contact patient’s PCP within 3 business days