Appendix E: Templates for the Pharmacy Smoking Cessation Program

Readiness Assessment

Name:	Date:

Please answer the questions below:

ASK	**1. Are you a smoker who is interested in quitting in the next month?**
	Yes or No
	2. Are you willing to set a QUIT date?
	Yes or No
	3. If you answered YES to these questions would you like to enrol in the Ontario Government's FREE Quit Smoking Program?
	Yes or No
ADVISE	**Quitting smoking is the most important thing you can do to protect your health now and in the future.** Evidence suggests smoking cessation programs can reduce the risk of chronic disease, other health complications, and subsequent use of the health care system. If you are willing to quit in the next 30 days your community pharmacist can help to establish the best option for you including pharmacological therapy and other support mechanisms.
	If you are interested in learning more about the FREE Quit Smoking Program, please ask your pharmacist.
ASSESS	**How Ready Are You?** How important is it for you to QUIT SMOKING for good? 1 (not at all) 2 3 4 5 6 7 8 9 10 (completely) How practical is it for you to quit NOW? 1 (not at all) 2 3 4 5 6 7 8 9 10 (completely) How confident are you to do what it takes to quit smoking FOR GOOD? 1 (not at all) 2 3 4 5 6 7 8 9 10 (completely)
	You may be ready to enrol!

After reviewing this form, please return it to your pharmacist.

Pharmacist:	Date:

To be filed for documentation and auditing purposes
If the patient has decided to enrol and is willing to set a quit date, the pharmacist may proceed with the consultation and agreement / consent forms

Pharmacy Smoking Cessation Program
Patient Agreement to Enrol & Patient Consent Form

Patient Name:	
Address:	
Phone:	
Email:	
Patient's Signature:	

Patient Enrolment

By signing the enrolment form, the patient agrees to work together with the pharmacist to stop smoking on the date indicated.

Pharmacist's Name:	
Pharmacist's Signature:	
Date of Enrolment:	
Expected QUIT Date:	

Patient Consent

It may be necessary for the pharmacist to discuss and share your health information with other health care professionals (e.g., physicians, nurses, etc.) in the process of assisting you with this quit smoking program.

By signing below, you authorize the pharmacist to disclose and collect your personal health information to and from other health care professionals who are or have provided medical services to you for the purpose of assisting you during this quit smoking program.

Please sign below to indicate your consent to this exchange of information.

Patient's Signature:	
Date:	
Comments (if any):	

To be completed prior to the first consultation meeting

Please note: It is important to set a QUIT date for program enrolment

To be filed for documentation and auditing purposes

Please provide a copy to the patient

FIRST QUIT CONSULTATION MEETING

Name:	**Date:**
Appointment location:	

Where possible, the First Quit Consultation should be an in person meeting at the pharmacy.
If in-person meeting is not possible, please indicate method of appointment

☐ In person ☐ Telephone ☐ Video-conferencing ☐ Email ☐ Other

ASSIST

Tobacco Use History: ☐ Daily smoker ☐ Occasional smoker

Current use: Number of cigarettes per day _____ for _____ years

# of Pack-years: Years smoked ____ x Packs per day: ____ = ____ Pack-years

How soon after waking is first cigarette? _____ minutes

Where do you smoke most often? _____

What time of day is smoking predominantly done? _____

Days of week predominantly smoking: _____

With whom do you smoke (alone or socially)? _____

Number of other household smokers: _____ Workplace smoking: (Yes/No) _____

Are you a source of 2nd hand smoke for family & friends? (Yes/No) _____

Number of previous attempts to quit (24 hrs or more of intentional stop): _____

Duration of Past Quit Attempts: _____

Previous methods used and reason for relapse, if applicable:

a. Patch: _____
b. Gum: _____
c. Losenge: _____
d. Inhaler: _____
e. Medication: _____
f. "Cold Turkey": _____
g. Hypnosis: _____
h. Other: _____

	From the methods indicated above, which was associated with the best results to date (from your perspective, e.g. not based on what you've heard)? _____ What led you to relapse? _____ Withdrawal symptoms: (Yes/No) _____ Negative mood: (Yes/No) _____ Habit: (Yes/No) _____ Being with other smokers: (Yes/No) _____ Stress: (Yes/No) _____ Other: _____ Do you drink (alcohol) when you smoke? (Yes/No) _____ Number of drinks per day: _____ Do you drink coffee when you smoke? (Yes/No) _____ Number of cups per day: _____ Are you under the care of your primary care provider for smoking cessation? (Yes/No) _____
ASSIST	**Medication Related History:** *May attach print out or MedsCheck if available* Allergies/Intolerance to medications: _____ Concurrent medications: Benzodiazepines: (Yes/No) _____ Antipsychotic: (Yes/No) _____ Antidepressants: (Yes/No) _____ Other: _____ **Chronic conditions and consequences of smoking:** Cardiac History: High Blood Pressure (Yes/No) _____ Blood Pressure: _____ Arrhythmia: (Yes/No) _____ Heart Rate: _____ Heart Failure: (Yes/No) _____ Hypercholesterolemia: (Yes/No) _____ Other heart related: _____ Diabetes: (Yes/No) _____ Type 1 _____ Type 2 _____ Respiratory History: Asthma (Yes/No) _____ COPD: (Yes/No) _____ Lung related problems: (Yes/No) _____ Past Seizure history: (Yes/No) _____ Cancer: (Yes/No) _____ Hormone Replacement Therapy: (Yes/No) _____ Oral contraceptives: (Yes/No) _____ Alcohol Use: _____ Depression: (Yes/No) _____ Anxiety: (Yes/No) _____ Eating disorder: (Yes/No) _____ Bipolar disease: (Yes/No) _____ Schizophrenia: (Yes/No) _____ Smoking-related health symptoms: ☐ Cough ☐ Wheeze ☐ Shortness of breath ☐ Distorted Smell/Taste ☐ Other _____

Smoking triggers and strategies to overcome them

Triggers:	**Strategies to consider:**
1. **2.** **3.** **4.** **5.**	☐ Set a quit date ☐ Start an exercise program ☐ Change diet/start healthy snacking ☐ Take up a new hobby/activity ☐ Get plenty of rest; ☐ Learn to relax/meditate ☐ Join a smoking cessation group forum ☐ Use quit smoking help-lines ☐ Get counselling ☐ Seek help/support from family/friends ☐ Spend more time with non-smokers ☐ Drink lots of water/cut down on alcohol ☐ Other (specify)

QUIT DATE:

CONSIDERING PHARMACOTHERAPY?

☐ Nicotine Patch ☐ Nicotine Gum ☐ Nicotine Lozenge ☐ Nicotine Inhaler

☐ Bupropion ☐ Varenicline ☐ None ☐ Other _____

Start date: _____ Dose: _____

Advice regarding drug therapy for this patient:

If experiencing adverse events, patient to contact:

OTHER NOTES:

Name of Pharmacist:

Refer to Section 7.3 for claims submissions (limit to one claim per year)

To be filed for documentation and auditing purposes

A copy may be provided to the patient

My Quit Plan

Plan for Preparation to Quit Smoking		
Name	Phone Number	Email

Quit Date:

Medication: (check all that apply)

☐ Nicotine Patch Start Date:	☐ Nicotine Gum Start Date:	☐ Nicotine Inhaler Start Date:	☐ Nicotine Lozenge Start Date:
☐ Bupropion Start Date:	☐ Varenicline Start Date:	☐ Other Start Date:	☐ No medication

Preparing environment:

Remove tobacco and smoking from:

☐ Home ☐ Work area ☐ Automobile ☐ Other _____

Possible challenges to anticipate:

☐ Stress	☐ Other smokers	☐ Drinking alcohol
☐ Nicotine urges	☐ Smoking cues	☐ Availability of cigarettes
☐ Weight gain	☐ Other	☐ Other

Strategies to overcome these challenges:

☐ Delay tactic	☐ Distraction strategies (e.g., walking)
☐ Places to avoid	☐ Places to go (where smoking prohibited)
☐ Use quit smoking help-lines	☐ Join a smoking cessation group forum
☐ Exercise program	☐ Change diet/start healthy snacking
☐ Take up a new hobby/activity	☐ Other

Next appointment date:

Pharmacist's Name:

Pharmacist's contact information:

Pharmacists to provide a copy for patient use; and a copy to attach to the patient's pharmacy file.