Ontario Pharmacists' Association

Ontario

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:

ASSESS

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: ______________________

Work place 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: ______________________
c. Inhaler: ______________________
d. Medication: ______________________
e. "Cold Turkey": ______________________
f. Hypnosis: ______________________
g. 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; ☐ Negative mood; ☐ Habit; ☐ Being with other smokers; ☐ Stress;

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 physician for smoking cessation? ☐ Yes / ☐ No

To be filed for documentation and auditing purposes: 2 years for audit under the ODB program
10 years as part of the patient health record

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ASSIST

Medication Related History: May attach print out or MedsCheck if available

Allergies / Intolerance to medications: ____________________

Concurrent medications: ☐ Benzodiazepines; ☐ Antipsychotic; ☐ Antidepressants;

☐ Other: ____________________

☐ Chronic conditions and consequences of smoking: ____________________

Cardiac History: ☐ High Blood Pressure; Blood Pressure: _________; ☐ Arrhythmia: Heart Rate: _________;

☐ Heart Failure; ☐ Hypercholesterolemia; ☐ Other heart related: ____________________

☐ Diabetes: ☐ Type 1 _________; ☐ Type 2 _________;

Respiratory History: ☐ Asthma; ☐ COPD;

☐ Lung related problems: ____________________

☐ Past Seizure history: ____________________

☐ Cancer: ____________________

☐ Hormone Replacement Therapy; ☐ Oral contraceptives: ____________________

☐ Alcohol Use: ____________________

☐ Depression; ☐ Anxiety; ☐ Eating disorders; ☐ Bipolar disease; ☐ Schizophrenia;

Smoking-related health symptoms: ☐ Cough; ☐ Wheeze; ☐ Shortness of breath; ☐ Distorted Smell/Taste

Smoking triggers and strategies to overcome them

Triggers:	Strategies to consider:
1.	☐ Set a quit date ☐ Start an exercise program ☐ Change diet/start healthy snacking
2.	☐ Take up a new hobby/activity ☐ Get plenty of rest; ☐ Learn to relax/meditate
3.	☐ Join a smoking cessation group forum ☐ Use quit smoking help-lines
4.	☐ Get counselling ☐ Seek help/support from family/friends
5.	☐ 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:

Submit electronic claim using PIN 93899941 $40

(limit to one claim per year) To be filed for documentation and auditing purposes. A copy may be provided to the patient.

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My Quit Plan

Plan for Preparation to Quit Smoking

Name:	Phone #:	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
Start Date: ___________________

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.

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