Ontario Pharmacists' Association

Ontario

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 ☐ No
	2. Are you willing to set a QUIT date?
	☐ Yes ☐ No
	3. If you answered YES to these questions would you like to enrol in the Ontario Government's FREE Quit Smoking Program?
	☐ Yes ☐ 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? (not at all) 1 2 3 4 5 6 7 8 9 10 (completely) How practical is it for you to quit NOW? (not at all) 1 2 3 4 5 6 7 8 9 10 (completely) How confident are you to do what it takes to quit smoking FOR GOOD? (not at all) 1 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: 2 years for audit under the ODB program
10 years as part of the patient health record

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

Quit Smoking Program
Patient Agreement To Enrol & Patient Consent Form

Patient Name:	
Address:	
Phone:	
Email:	

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

Patient's Signature:	
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.
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.

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10 years as part of the patient health record