Tobacco Cessation Initial Assessment

This tool is to be used in conjunction with the PSFC Canadian Pharmacist Smoking Cessation Pharmacotherapy Algorithm available at www.psfcnetwork.com

Date:_____ (DD/MM/YY) Store Identifier:_____ Pharmacist Initials:_____

TO BE COMPLETED BY THE CLIENT (or Pharmacy Team Member)

Tell Us A Little About You:

Last Name:_____ First Name:_____

Address:_____

Contact Information:

Phone#: (____) ____-_____ Email:_____

Date of Birth:_____ (DD/MM/YY) Health Card Number:_____

Tell Us About Your Current Tobacco or E-cigarette Use: (Check All That Apply)

☐ **Cigarettes**	☐ I Smoke Daily	Tell Us How Many: ☐ Less Than 10 ☐ 10-19 ☐ 20-29 ☐ 30-39 ☐ 40 Or More #_____
	☐ I Do Not Smoke Every Day	Tell Us About How Much And How Often:_____
☐ **Cigars** ☐ **Cigarillos**	☐ I Smoke Daily ☐ I Do Not Smoke Every Day	Tell Us About How Much & How Often:_____
☐ **Chew Tobacco/Snus/Snuff** ☐ **Shisha**	☐ I Use Daily ☐ I Do Not Use Every Day	Tell Us About How Much And How Often:_____
☐ **E-cigarette or Vape**	☐ With Nicotine ☐ Without Nicotine ☐ Not Sure If It Has Nicotine	If Your Vape Has Nicotine, Tell Us How Much It Has, If You Know: _____mg/ml or _____%
	☐ I Vape Daily ☐ I Do Not Vape Every Day	Tell Us About How Much And How Often:_____

Tell Us About Any Past Quit Attempts. Did You Try Any Of The Following And What Were The Results?

☐ **Nicotine Patch**	☐ I Quit For A While	☐ It Did Not Work	☐ I Had Side Effects I Did Not Like
☐ **Nicotine Gum**	☐ I Quit For A While	☐ It Did Not Work	☐ I Had Side Effects I Did Not Like
☐ **Nicotine Lozenge**	☐ I Quit For A While	☐ It Did Not Work	☐ I Had Side Effects I Did Not Like
☐ **Nicotine Inhaler**	☐ I Quit For A While	☐ It Did Not Work	☐ I Had Side Effects I Did Not Like
☐ **Nicotine Spray**	☐ I Quit For A While	☐ It Did Not Work	☐ I Had Side Effects I Did Not Like
☐ **Bupropion/Zyban**	☐ I Quit For A While	☐ It Did Not Work	☐ I Had Side Effects I Did Not Like
☐ **Varenicline/Champix**	☐ I Quit For A While	☐ It Did Not Work	☐ I Had Side Effects I Did Not Like
☐ **Cytisine/Cravv**	☐ I Quit For A While	☐ It Did Not Work	☐ I Had Side Effects I Did Not Like
☐ **Cold Turkey**	☐ I Quit For A While	☐ It Did Not Work	
☐ **I Tried To Slowly Cut Back**	☐ I Quit For A While	☐ It Did Not Work	
☐ **Other:**	☐ Hypnosis	☐ Laser	☐ Acupuncture
	Comments:		

Tell us a bit about your lifestyle to help us pick the best quit method for you:

Do You Use Caffeine Daily? (Caffeine Levels Increase When Quitting)

☐ Yes ☐ With Tobacco/Vape?
☐ No

If Yes, what caffeinated beverages do you drink?

☐ Coffee ☐ Tea ☐ Cola/Energy Drink

Do You Smoke/Vape Cannabis?

☐ Yes
☐ No

If Yes, do you add tobacco to it? ☐ Yes ☐ No

Do You Drink Alcohol? (May Interact With Some Quit Medications)

☐ Yes ☐ With Tobacco/Vape
☐ No

If Yes, which best describes how often you use it: ☐ Daily ☐ A Few Times a Week ☐ On The Weekends ☐ On Special Occasions

Tell Us If You Have (Or Think You Have) Any Of The Following:

☐ Heart Disease ☐ High Blood Pressure ☐ Lung Disease ☐ Cancer
☐ Seizures/Epilepsy ☐ Skin Problems like Eczema or Psoriasis or Sensitive Skin ☐ Depression ☐ Trouble Sleeping
☐ Eating Disorder ☐ Bipolar ☐ Schizophrenia ☐ Anxiety

Are You Pregnant And Or Breastfeeding?

☐ No ☐ Pregnant ☐ Trying To Become Pregnant ☐ Breastfeeding

Tell Us A Bit About What You Want To Change About Your Tobacco Use:

☐ I'd like to quit as soon as possible/or within the next month
☐ I'd like to quit, but I don't know if I am ready to set a quit date yet
☐ I'd like to start by cutting back on how much I use and then quit later
☐ I'd like to cut back on how much I use for now
☐ Other:_____

Do You Have Any Insurance That Will Help You Pay For The Cost Of Any Quit Medications?

☐ Yes ☐ No ☐ I'm Not Sure

TO BE COMPLETED BY PHARMACIST:

GOAL:

☐ Reduce ☐ Reduce-to-Quit Quit Within: ☐ 2/52 ☐ 4/52 ☐ Other_____

☐ Start / Quit Date:_____ (DD/MM/YY)

METHOD: (Consider Current Medications, Contraindications, and Drug Interactions When Making Selection)

Counselling:	☐ In Person	☐ Phone	☐ Refer to Quit Line or Other Service	☐ Other:_____
Quit Medication(s): (Check all that Apply)	☐ NRT Patch ☐ NRT Lozenge	☐ NRT Spray ☐ Varenicline	☐ NRT Inhaler ☐ Cytisine	☐ NRT Gum ☐ Bupropion
Prescription Required?	☐ Yes - Date Rx Provided:_____ (DD/MM/YY) ☐ No		☐ Date Rx Started:_____ (DD/MM/YY)	

COMMENTS / PLAN DETAILS: (Pharmacotherapy details, special instructions for follow up, etc.)

NEXT FOLLOW-UP:

Date:_____ (DD/MM/YY) Time:____:_____ ☐ AM ☐ PM

Method of Contact: ☐ In Person ☐ Phone ☐ Email ☐ Text

Permission To Leave Message? ☐ Yes ☐ No

Other:_____