

Smoking Cessation Program: Consult Form – Primary Care



**Fax form: PEI Smoking
Cessation Program
902-620-3354**

Date: DD/MM/YY

(fill in below or apply patient label)

Patient PHN/MRN: _____

First Name: _____

Last Name: _____

Date of Birth: DD/MM/YY

Gender: ☐ Male ☐ Female ☐ Identify as: _____

(If no contact info on patient label, also fill in below) ☐ Mail Quit Kit (check if required)

Address: _____ Postal Code: _____

Tel: _____ Email (if available): _____

LOCATION: ☐ Kings PC ☐ Queens East PC ☐ Queens West PC ☐ East Prince PC ☐ West Prince PC ☐ PEI Cancer Treatment Centre
☐ Cardiac and Pulmonary Rehab ☐ Acute Care ☐ Home Care ☐ Lennox Island ☐ Own Health

TOBACCO AND VAPE PRODUCT USE HISTORY

Please complete the following questions:

1. Have you used any form of tobacco or vape products in the past 6 months? ☐ Yes ☐ No (If YES, continue)

2. Have you used any form of tobacco or vape products in the past 7 days? ☐ Yes ☐ No (If YES, continue)

3. What form(s) of tobacco do you currently use? ☐ Cigarettes ☐ Cigars ☐ Pipes ☐ Smokeless ☐ Vaping Device
☐ Other: _____

4. How much do you smoke/vape per day? (# of cigarettes/cigars/vapes, etc.) _____ (# per day/mg)
If not a daily smoker/vaper, how much per month? _____ (# per month)

5. How many years have you smoked/vaped? _____ years

6. How many minutes after waking up do you first smoke/vape? _____ (# of minutes)

7. How many quit attempts (lasting equal to or greater than 24 hours) have you made in the past year? _____
(a) How many of these quit attempts were supported with NRT or medication? _____
(b) What has been your longest quit attempt (e.g. days/weeks/months, etc.)? _____

8. What previous smoking cessation methods have you tried?
☐ Cessation Medication ☐ Patch ☐ Other NRTs ☐ "Cold Turkey" ☐ Other: _____

9. Do you currently use vaping devices (e.g. E-cigarettes, vape pens, etc.)? ☐ Yes ☐ No
a. If yes, do you use vaping devices as a cessation aid? ☐ Yes ☐ No

10. Do others smoke in the home? ☐ Yes ☐ No

11. In which of these settings are you regularly exposed to second-hand smoke? (check all that apply)
☐ At Home ☐ At School ☐ In the Car ☐ At Work ☐ At Social Events ☐ Other: _____ ☐ Not Exposed

12. How important is it to you to quit smoking/vaping? Please circle (not) 1 2 3 4 5 (very)

13. How confident are you that you can quit smoking/vaping? Please circle (not) 1 2 3 4 5 (very)

Provide personalized advice to quit smoking ☐ Yes ☐ No

Is patient ready to quit smoking/vaping? ☐ YES

☐ No

Quit Date: DD/MM/YY

☐ Has quit within the last 6 months

☐ Is planning to quit in the next 6 months

☐ Is planning to quit today

☐ Is not ready to quit in the next 6 months

☐ Is planning to quit in the next month

Patient must answer 4 or 5 to questions #12 and #13, must be interested in quitting in the next month, and must be willing to set a quit date for enrollment into the Provincial Smoking Cessation Program.

SELECT QUIT SMOKING MEDICATION <input type="checkbox"/> Reviewed Contraindications						
<input type="checkbox"/> Nicotine Replacement Therapy (NRT) <i>Dose and duration of NRT should be titrated based on patient's needs</i>	# cigarettes smoked/day <input type="checkbox"/> Long Acting NRT Patch Starting Dose: <i>*Smoke within 30 minutes of waking, add 7 mg to initial starting dose.</i>	<10 cigs/day <input type="checkbox"/> 7 mg <input type="checkbox"/> 14 mg	10-19 /day <input type="checkbox"/> 14 mg <input type="checkbox"/> 21 mg	20-29 /day <input type="checkbox"/> 21 mg <input type="checkbox"/> 28 mg	30-39 /day <input type="checkbox"/> 35 mg <input type="checkbox"/> 42 mg	40+ /day <input type="checkbox"/> 42 mg
<input type="checkbox"/> Short Acting NRT		<input type="checkbox"/> Inhaler <input type="checkbox"/> Gum (<input type="checkbox"/> 2mg or <input type="checkbox"/> 4 mg) <input type="checkbox"/> Lozenge (<input type="checkbox"/> 1mg or <input type="checkbox"/> 2mg or <input type="checkbox"/> 4 mg) <input type="checkbox"/> Spray (<input type="checkbox"/> 1mg or <input type="checkbox"/> 2mg) <i>For use on own or combined with patch (PRN) [Note: Patients are only covered for <u>one</u> method under the Smoking Cessation Program]</i>				
<input type="checkbox"/> Varenicline <input type="checkbox"/> Bupropion <input type="checkbox"/> Review appropriate use, dose, duration of medication		Notes: <input type="checkbox"/> No medication				
VAPING CESSATION ASSESMENT: coverage limited to NRT products and does not cover prescription medications. <i>*If unsure of light or heavy user, choose 21mg (moderate vape user)</i>						
<input type="checkbox"/> Light Vape User (0-20mg per day): 14mg Periodic use; no cravings; withdrawal symptoms		<input type="checkbox"/> Moderate Vape User (20-40mg per day): 21 mg Stable use; habitual cravings; withdrawal symptoms; vape within 30 minutes of waking		<input type="checkbox"/> Heavy Vape User (40mg+ per day): 35 mg Increasing use; intolerable cravings; withdrawal symptoms; vape within 30 minutes of waking		
STRATEGIC ADVICE						
<input type="checkbox"/> Remind to cut back on caffeine consumption 50% on quit date <input type="checkbox"/> Review common risks of relapse (stress, alcohol, other smokers) <input type="checkbox"/> Recommend strategies for managing cravings and withdrawal				<input type="checkbox"/> Explain that changes in mood may occur in the short term <input type="checkbox"/> Provide Quit Kit and other resources <input type="checkbox"/> Offer follow up/additional supports		
ARRANGE FOLLOW-UP						
Provider Follow-up: <input type="checkbox"/> 3 days after quit date <input type="checkbox"/> 7 days after quit date <input type="checkbox"/> 14 days after quit date Additional option: <input type="checkbox"/> Smokers' Helpline: Fax Smokers' Helpline referral form <input type="checkbox"/> Yes <input type="checkbox"/> No Assess Risk for COPD if >age 40 <input type="checkbox"/> Patient has a diagnosis of COPD <input type="checkbox"/> Canadian Lung Health Test completed						

PATIENT ACKNOWLEDGMENT

☐ I understand that the PEI Department of Health and Wellness may contact me for the purposes of program evaluation. My participation in a follow-up survey is completely voluntary and my decision to participate will not affect the services I receive through this program.

If you have any questions about the collection of this information you may contact the Chief Public Health Office at 902-368-4319.

- ☐ Patient is being referred to the PEI Smoking Cessation Drug Cost Assistance Program and verbal consent obtained.
☐ Patient is NOT being referred to the PEI Smoking Cessation Drug Cost Assistance Program at this time.

Signature of health care provider: _____

Date: DD/MM/YY

Telephone Number: _____

Personal Health Information on this form is collected under the Prince Edward Island's *Health Information Act*, as it relates to and is necessary for determining assessment of needs and eligibility for benefits under the PEI Pharmacare Program (Smoking Cessation Program). If you have any questions about this collection of Personal Health Information, you may contact the Provincial Tobacco Control Coordinator at 902-368-4319.