Smoking Cessation Drug Cost Assistance Program Intake Form

Health PEI
One Island Health System
Santé Î.-P.-É.
Un système de santé unique

Fax form to Pharmacy & PEI Pharmacare Program 902-368-4905

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***)

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

TO BE FILLED OUT BY CLINICIAN FOR PATIENTS SEEKING TO PARTICIPATE IN PROVINCIAL SMOKING CESSATION PROGRAM

❑ Is planning to quit today **Quit Date**: DD/MM/YY

❑ Is planning to quit in the next month

SMOKING CESSATION ACTION PLAN RECOMMENDATIONS

SELECT QUIT SMOKING MEDICATION ❑ **Reviewed Contraindications**

The following recommendations for a smoking cessation plan are being made by the clinician, based on the consultation assessment.

❑ **Nicotine Replacement Therapy (NRT)** ***NB: Dose and duration of NRT should be titrated based on patient's needs*

Starting Dose:	❑ **7 mg**	❑ **14 mg**	❑ **21 mg**	❑ **28 mg**	❑ **35 mg**	❑ **42 mg**
❑ **Patch**	7 mg x 6 wks.	14 mg x 6 wks. 7 mg x 4 wks.	21 mg x 6 wks. 14 mg x 4 wks. 7 mg x 2 wks.	28mg (21mg + 7mg) x 6 wks. 21 mg x 4 wks. 14 mg x 2 wks. 7 mg x 2 wks.	35mg (21mg + 14mg) x 6 wks 28mg (21mg + 7mg) x 4 wks. 21 mg x 2 wks. 14 mg x 2 wks. 7 mg x 2 wks.	42 mg (21mg + 21mg) x 6 wks. 35mg (21mg + 14mg) x 4 wks. 28mg (21mg + 7mg) x 2 wks. 21 mg x 2 wks. 14 mg x 2 wks. 7 mg x 2 wks.

❑ **Short Acting NRT**	❑ **Inhaler**	❑ **Gum:** 2mg ❑ **Gum:** 4mg	❑ **Nicorette® Lozenge**: 2mg ❑ **Nicorette® Lozenge:** 4mg	❑ **Thrive® Lozenge**: 1mg ❑ **Thrive® Lozenge**: 2mg
❑ **Varenicline** ❑ **Buproprion** ❑ Reviewed appropriate use, dose, duration of medication	**Notes:** ❑ **No medication**			

❑ **Advised patient to wait one business day to allow time to enroll patient in the Provincial Smoking Cessation Program.**

❑ **Provide patient with a copy of Intake Form to bring to their Pharmacy.**

Intake Form and Assessment Completed by: _____ Signature: _____

(name of clinician)