Smoking Cessation Program: Follow Up Form – Primary Care

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

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

Date: DD/MM/YY **Quit Date:** DD/MM/YY

❑ 3 days after quit date ❑ 7 days after quit date ❑ 14 days after quit date
❑ 1 Month ❑ 2 Months ❑ 3 Months ❑ 4 Months ❑ 5 Months ❑ 6 Months

Patient PHN/MRN: _____
First Name: _____
Last Name: _____
Date of Birth: DD/MM/YY

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

ASSESS SMOKING STATUS

Have you used any form of tobacco/vaping products in the past 7 days?	❑ No ❑ Yes → Within 30 minutes of waking? ❑ No ❑ Yes cigs/day:_____ Amt Vaped/day _____mg Reason Relapse:

MEDICATIONS MANAGEMENT

Are you still using the quit smoking medications we recommended?	❑ No ❑ Yes →	Type: Dose:
Do you have any questions or concerns about the medication?	❑ No ❑ Yes	

WITHDRAWAL & SIDE EFFECTS

Have you experienced any of the following symptoms?
Rate Severity (Mild [0] – Severe [4]

❑nausea	❑0	❑1	❑2	❑3	❑4
❑headache	❑0	❑1	❑2	❑3	❑4
❑sleep disturbance	❑0	❑1	❑2	❑3	❑4
❑skin irritation	❑0	❑1	❑2	❑3	❑4
❑restlessness	❑0	❑1	❑2	❑3	❑4
❑difficulty concentrating	❑0	❑1	❑2	❑3	❑4
❑other: _____	❑0	❑1	❑2	❑3	❑4

MOOD CHANGES

Have you or your family/friends noticed any changes to your mood since quitting?
Rate Severity (Mild [0] – Severe [4]

❑anger/hostility	❑0	❑1	❑2	❑3	❑4
❑anxiety	❑0	❑1	❑2	❑3	❑4
❑feeling depressed	❑0	❑1	❑2	❑3	❑4
❑other: _____	❑0	❑1	❑2	❑3	❑4

CAFFEINE USE How many caffeinated beverages are you drinking per day?	❑0 ❑1-2 ❑2-4 ❑>4
CRAVINGS Have you had any cravings to smoke/vape?	❑ No ❑ Yes

RELAPSE RISK

Have there been any situations that made you feel like you were at risk for going back to smoking/vaping?	❑ No ❑ Yes
From 1 – 10, with 10 being most confident, how confident are you that you can quit smoking/vaping or stay quit?	❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

QUIT SMOKING MEDICATION ADJUSTMENT (If making adjustment, new Intake Form is required)

❑ Nicotine Replacement Therapy (NRT) ***NB: Dose and duration of NRT should be titrated based on patient's needs*	❑ **Patch** *Starting Dose:*	❑ **7 mg**	❑ **14 mg**	❑ **21 mg**	❑ **28 mg**	❑ **35 mg**	❑ **42 mg**
	❑ **Short Acting NRT**	❑ **Inhaler** ❑ **Gum** (❑ 2mg or ❑ 4 mg) ❑ **Lozenge** (❑ 1mg or ❑ 2mg or ❑ 4 mg) ❑ **Spray** (❑ 1mg or ❑ 2 mg) *For use on own or combined with patch (PRN)* ***Note:*** *Patients are only covered for one method under the Smoking Cessation Program*					

❑ **Varenicline** ❑ **Buproprion** ❑ Reviewed appropriate use, dose, duration of medication	**Notes:** ❑ **No medication**

Relapse Prevention Plan

Issue:	Plan:

Notes and Comments:
Follow Up Plan: _____ weeks

Name of health care provider (signature) _____ **Telephone Number:** _____