Smoking Cessation Consult Form – Primary Care

Health PEI
One Island Health System
Santé Î.-P.-É.
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Date: DD/MM/YY

Patient PHN/MRN: _____

First Name: _____

Last Name: _____

Date of Birth: DD/MM/YY

Gender: ❑ Male ❑ Female ❑ Another gender: _____

Address: _____

Postal Code: _____

Phone (H/ M/ W): _____

Email: _____

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

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

TOBACCO USE HISTORY *Please complete the following questions:*

1. Have you used any form of tobacco in the past 6 months? ❑ Yes ❑ No ***(If YES, complete 2.)***
2. Have you used any form of tobacco in the past 7 days? ❑ Yes ❑ No
3. What form(s) of tobacco do you currently use? ❑ Cigarettes ❑ Cigars ❑ Pipes ❑ Smokeless ❑ Other: _____
4. How much do you smoke per day? (# of cigarettes/cigars/etc.) _____ **(# per day)**
   If not a daily smoker, how much per month? _____ **(# per month)**
5. How many years have you smoked? _____ Years
6. How many minutes after waking up do you first smoke? _____ **(# 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" ❑ Vaping devices ❑ Other: _____
9. Do others smoke or vape in the home? ❑ Yes ❑ No
10. 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
11. How important is it to you to quit smoking? **Please circle** (*not*) 1 2 3 4 5 (*very*) 9 (NA)
12. How confident are you that you can quit smoking? **Please circle** (*not*) 1 2 3 4 5 (*very*) 9 (NA)

VAPE PRODUCT USE HISTORY *Please complete the following questions:*

13. Have you used any vape products in the past 6 months? ❑ Yes ❑ No ***(If YES, complete 14)***
14. Have you used any vape products in the past 7 days? ❑ Yes ❑ No
15. Do you currently use vaping devices (e.g. *E-cigarettes, vape pens, etc.*) as a tobacco cessation aid? ❑ Yes ❑ No
16. How much do you vape per day? _____ **(# mg)**
    If not a daily vaper, how much per month? _____ **(# mg per month)**
17. How many years have you vaped? _____ years
18. How many minutes after waking up do you first vape? _____ **(# of minutes)**
19. 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? _____
    (b) What has been your longest quit attempt (eg. days/weeks/months, etc.)? _____

20. What previous vaping cessation methods have you tried?
❑ Patch ❑ Other NRTs ❑ "Cold Turkey" ❑ Other: _____

21. Do others vape or smoke in the home? ❑ Yes ❑ No

22. 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

23. How important is it to you to quit vaping? **Please circle** (*not*) 1 2 3 4 5 (*very*) 9 (NA)

24. How confident are you that you can quit vaping? **Please circle** (*not*) 1 2 3 4 5 (*very*) 9 (NA)

❑ ***Provide personalized advice to quit smoking***

Is patient ready to quit smoking? ❑ **YES** ❑ **No** ❑ **N/A**

Quit Date: DD/MM/YY _____

❑ Has quit within the last 6 months
❑ Is planning to quit today
❑ Is planning to quit in the next month
❑ Is planning to quit in the next 6 months
❑ Is not ready to quit in the next 6 months

❑ ***Provide personalized advice to quit vaping***

Is patient ready to quit vaping? ❑ **YES** ❑ **No** ❑ **N/A**

Quit Date: DD/MM/YY _____

❑ Has quit within the last 6 months
❑ Is planning to quit today
❑ Is planning to quit in the next month
❑ Is planning to quit in the next 6 months
❑ Is not ready to quit in the next 6 months

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

Name of health care provider (signature) _____ ***Date*** DD/MM/YY _____

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.