Smoking Cessation Consult Form – Primary Care

Health PEI
One Island Health System

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Fax Form to:
PEI Smoking Cessation Program
(902) 620-3354

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: _____

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 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***

Is patient ready to quit smoking/vaping?
Quit Date: DD/MM/YY

❑ **YES**
- ❑ Has quit within the last 6 months
- ❑ Is planning to quit today
- ❑ Is planning to quit in the next month

❑ **No**
- ❑ Is planning to quit in the next 6 months
- ❑ Is not ready to quit in the next 6 months

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	❑ Review Contraindications					
❑ Nicotine Replacement Therapy (NRT) ***NB: Dose and duration of NRT should be titrated based on patient's needs*	# cigarettes smoked/day ❑ **Patch** Starting Dose: If smoke within 30 minutes of waking, add 7 mg to initial starting dose.	**<10 cigs/day** ❑ 7 mg ❑ 14 mg	**10-19 /day** ❑ 14 mg ❑ 21 mg	**20-29 /day** ❑ 21 mg ❑ 28 mg	**30-39 /day** ❑ 35 mg ❑ 42 mg	**40+ /day** ❑ 42 mg
	❑ ***Short Acting NRT***	❑ **Inhaler** ❑ **Gum** (❑ 2mg or ❑ 4 mg) ❑ **Lozenge** (❑ 2mg or ❑ 4 mg) ❑ **Mouth Spray** *For use on own or combined with patch (PRN)* *[**Note**: Patients are only covered for one method under the Smoking Cessation Drug Cost Assistance Program, and mouth spray is not currently covered under the Smoking Cessation Drug Cost Assistance Program]*				
❑ **Varenicline** ❑ **Buproprion** ❑ Review appropriate use, dose, duration of medication		**Notes:** ❑ **No medication**				

VAPING CESSATION ASSESMENT: coverage limited to NRT products and does not cover prescription medications
*If unsure of light or heavy user, choose 21mg (moderate vape user)

❑ **Light Vape User (0-20mg per day):** 14mg Periodic use; no cravings; withdrawal symptoms	❑ **Moderate Vape User (20-40mg per day):** 21 mg Stable use; habitual cravings; withdrawal symptoms; vape within 30 minutes of waking	❑ **Heavy Vape User (40mg+ per day):** 28 mg Increasing use; intolerable cravings; withdrawal symptoms; vape within 30 minutes of waking

STRATEGIC ADVICE

❑ Remind to cut back on caffeine consumption 50% on quit date	❑ Explain that changes in mood may occur in the short term
❑ Review common risks of relapse (stress, alcohol, other smokers)	❑ Provide Quit Kit and other resources
❑ Recommend strategies for managing cravings and withdrawal	❑ Offer follow up/additional supports

ARRANGE FOLLOW-UP

Provider Follow-up:
❑ 3 days after quit date ❑ 7 days after quit date ❑ 14 days after quit date

Additional option:
❑ Smokers' Helpline: Fax Smokers' Helpline referral form ❑ Yes ❑ No

Assess Risk for COPD if >age 40 ❑ Patient has a diagnosis of COPD ❑ 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. Myparticipation 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 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.