# Smoking Cessation Follow Up Consult Form – Primary Care

Health PEI
One Island Health System
Santé Î.-P.-É.
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**Fax form to: 902-620-3354**
**PEI Smoking Cessation Program**

**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 ❑ Home Care

## ASSESS SMOKING STATUS

| | |
|---|---|
| Have you used any form of tobacco/vaping products in the past 7 days? | ❑ No<br>❑ Yes → Within 30 minutes of waking? ❑ No ❑ Yes cigs/day:<br>Reason Relapse: |

## MEDICATIONS MANAGEMENT

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

## 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 your 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)<br>***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** (❑ 2mg or ❑ 4 mg) ❑ **Mouth Spray**<br>*For use on own or combined with patch (PRN)*<br>*[**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 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)*** _____