# Smoking Cessation Follow Up Consult Form – Primary Care

Health PEI
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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 |
| | ❑ Yes ➡ Within 30 minutes of waking? ❑ No ❑ Yes cigs/day: |
| | 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])

| Symptom | | | | | |
|---|---|---|---|---|---|
| ❑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])

| Mood | | | | | |
|---|---|---|---|---|---|
| ❑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)

***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**
  *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 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)*** ______________________

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