Form 1: Readiness to Quit
CONFIDENTIAL

Patient Information		
Name:	Date of birth:	
Sex: ☐ Male ☐ Female ☐ Other	PHIN:	
Home address:	City & Province:	Postal code:
Phone (cell):	Phone (home):	E-mail:

Primary Care Provider Information		
Name:	Phone:	Fax:

Readiness Assessment	
How important is it for you to quit for good?	
How confident are you that you can quit for good?	
How ready are you to quit within the next 30 days?	
When would you like to stop using tobacco products by? (QUIT date)	
What are your motivations for quitting smoking? ☐ Family/relationships ☐ Improve general health ☐ Other existing illnesses ☐ Financial ☐ Other:	
Would you like to enrol in the program?	Date of enrolment:

Enrolment Confirmation	
Patient signature:	Pharmacist signature:
**By signing this enrolment form, I (the patient) agree to work with the pharmacist to stop smoking by the proposed QUIT date and consent to sharing my health information with other healthcare providers as needed.*	**By signing this enrolment form, I (the pharmacist) agree to assist the patient in quitting smoking including conducting mandatory patient follow-up appointments at 6 and 12 months.*
Date of initial assessment appointment:	

Initiative Evaluation Consent	
Patient signature:	Date of Consent:
**I understand that my results will be used for evaluation of this smoking cessation initiative only and not myself in any form, and consent to be being contacted to provide feedback.*	

FOR PHARMACIST USE ONLY (Pharmacist Information)	
Pharmacist:	Pharmacy Provider #:
Pharmacist License #:	
Phone #:	Fax #:

PHARMACISTS MANITOBA

Form 2: Initial Assessment & Plan
CONFIDENTIAL

Date of consult:	Patient name:	PHIN:
Address:	City & Province:	Postal code:

Medication & Medical History

Do you have any chronic medical conditions? Check if well controlled.	☐ 1. ☐ 3.	☐ 2. ☐ 4.

Do you take any prescription, OTC, or natural medications?

Agent	Strength	Form	Dosing	Indication

Do you drink alcohol or coffee? How often and how much?	Alcohol: Coffee:
Do you use cannabis or other drugs?	
☐ Pregnant ☐ Breastfeeding	Allergies & reactions:

Tobacco Use Habits & History

How many years have you been smoking?		
What types of tobacco products do you use? How much of each product do you use per day?	1. 2. 3.	
What kind of smoker would you describe yourself as? Check all that apply.	☐ Daily ☐ Occasional	☐ Social ☐ Alone
Where do you usually smoke? Check all that apply.	☐ Home ☐ Car ☐ Leisure activities	☐ Work ☐ Social gatherings ☐ Others:
Who in your immediate regular life also smokes? Check all that apply.	☐ Friends ☐ Family (household) ☐ Significant other	☐ Co-workers ☐ Family (non-household) ☐ Others:

Add the scores preceding the selected answers in the portion below to determine Fagerstrom nicotine dependency

How soon after waking do you smoke your first cigarette?	
Is it hard to not smoke in places where it's not allowed?	
Which cigarette would you hate to give up most?	
How many cigarettes a day do you smoke? Exact amount:	
Do you smoke more during the morning than rest of the day?	
Do you smoke even if you are sick in bed most of the day?	

Dependence:	0-2 =very low	3-4 = low	5 = moderate	6-7 = high	≥8 = very high	

Past Quit Attempts

How many times have you tried quitting before?	When was your last quit attempt?
Which instance and method were your most successful?	What is the longest period of time you've quit for?

What led you to resume using tobacco products each time?

What have you used/tried in the past to quit smoking? How did you use them?

Agent/Method	Dose/Directions	Reason/s for stopping	Duration Used	Still using?

PHARMACISTS MANITOBA

Form 2: Initial Assessment & Plan
CONFIDENTIAL

My quit day is . I am proud of this decision but understand I may have cravings and withdrawal symptoms. These are only temporary, will improve over time, and I can use the personalized strategies outlined below to manage them. If I have any concerns before my next appointment, I can reach my pharmacist at - .

Plan (Pharmacological)

Patient preferences/concerns (efficacy, convenience, cost/coverage, discretion, interactions, side effects, dosing)

Prescriber: Address:

Name: Address:

Medication	Strength & Quantity	Directions	Refills

Signature: Date: Price:

Monitoring (side-effects, timeframe, endpoints)

Plan (Behavioral)

What are your biggest concerns we should address to making quitting easier? (Check all that apply)

☐ Cravings ☐ Mood ☐ Sleep ☐ Habit
☐ Stress ☐ Social ☐ Hunger/weight gain ☐ Others:

	Patient Concerns	Recommendations
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		

Next Appointment

Date of 1st follow-up	Week of:
Preferred method	☐ Telephone ☐ In-person

(Form 3: Follow-up)

Date of consult:	Patient name:	PHIN:
Address:	City & Province	Postal code:

Follow-up Record (check appropriate box)

Date: | Method: ☐ Call ☐ In-person ☐ Unable to reach (min 3 attempts)

Was this a mandatory consult? If yes, check accordingly. ☐ 6 month ☐ 12 month

Complete If This Is Either a 6 or 12 Month Follow Up

Quit Status Assessment at: ☐ 6 month ☐ 12 month

Has patient successfully *quit** tobacco products? ☐ Yes ☐ No

**Definition of 'quit' – Participant has sustained smoking cessation for a minimum of thirty (30) continuous days immediately preceding the date six (6) or twelve (12) months after their initial assessment.*

Medication Management

How have the medications been working out?

Agent	Side-effects	Effect on cravings	Frequency of use

Smoking Habits & Behavioral Strategies

Have you used any tobacco or tobacco-like products since we last spoke? ☐ Yes ☐ No

If yes, what were the circumstances in each slip-up?

Date & Time	# cigs	Place	With Whom	Trigger

What have been your biggest challenges since we last spoke? How have you handled them?

	Previous patient concerns	Alternative recommendations
1		
2		
3		
4		
5		

Were there any additional concerns that came up since we last spoke?

	Additional patient concerns	Recommendations
1		
2		
3		
4		
5		

PHARMACISTS MANITOBA

Smoking Symptoms & Symptoms of Withdrawal						
0 = no symptoms, 5 = worst ever						
	0	1	2	3	4	5
Cough	☐	☐	☐	☐	☐	☐
Shortness of breath (exertion)	☐	☐	☐	☐	☐	☐
Shortness of breath (at rest)	☐	☐	☐	☐	☐	☐
Phlegm production	☐	☐	☐	☐	☐	☐
Cold hands/feet	☐	☐	☐	☐	☐	☐
Cravings	☐	☐	☐	☐	☐	☐
Irritability	☐	☐	☐	☐	☐	☐
Depressed mood	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐
Trouble concentrating	☐	☐	☐	☐	☐	☐
Trouble sleeping	☐	☐	☐	☐	☐	☐

Next Appointment		
Date of next follow-up	Week of:	
Preferred method	☐ Call	☐ In-person