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| **STAFF TO COMPLETE THIS SECTION** |
| **Surname:** |  |  **First Name**: |  | **Mr/Mrs/Ms/ Other** |  |
| **Address:** |  |
| **Postcode:** |  | **Email:** |  |
| **Daytime tel no:** |  |  **Mobile no:** |  |
| **Date of Birth:** |   | **Age *(in* years):** |  |  **Male / Female:** |  |

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| **OCCUPATION STATUS Please tick (✓) relevant box** |
| Full Time Student |  | Routine manual |  |
| Never Worked / Unemployed |  | Managerial/ Professional |  |
| Home Carer |  | Intermediate (e.g. Supervisor) |  |
| Sick / Disabled and unable to work |  | Retired |  |

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| **Do you or have you suffered from any of the following? Please tick (✓) relevant box(es)** |
| Heart Disease |  | TIA |  | Hepatic Impairment |  |
| Diabetes |  | Anxiety |  | Mental Disorders |  |
| COPD |  | Depression |  | Epilepsy or Fits |  |
| Asthma |  | Skin Conditions |  | None of the Above |  |
| Hyperthyroidism |  | Peptic Ulcer |  | Other (Please State) |  |
| History of Stroke |  | Renal Impairment |  |  |  |

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| How would you describe your general health over the last 12 months? **Please tick (✓) relevant box** |  |  |
| Excellent  |  | Poor |  |
| Good |  | Very Poor |  |
| Moderate |  | Information not available |  |

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| **Smoking Assessment**  |
| Tobacco Smoked **Please tick relevant box** | **(✓)** | If female are you: **Please tickrelevant box** | **(✓)** | Why do you want to quit? **Please tick all that apply** | **(✓)** |
| Cigarettes |  | Planning a pregnancy |  | Prevent ill health |  |
| Cigars |  | Pregnant |  | Experiencing ill health |  |
| Rolling Tobacco |  | Breast Feeding |  | Family health |  |
| Other (Please state) |  | Not Applicable |  | Save money |  |
| Information not available |  |  |  | Pregnancy |  |
| How long Smoking? (Years) |  |  |  | Fertility |  |
| Cigarettes per day (number) |  |  |  | Hospital Admission |  |
|  |  |  |  | Quit before |  |
|  |  |  |  | Other (Please state) |  |
|  |  |  |  | Information not available |  |
|  |
| Previous Quit Attempt (Y/N) |  | **Client referred to:** | Date last smoked |  |
| Any Smokers in the family (Y/N) |  | Other Stop Smoking Service |  | Agreed Quit Date |  |
|  | GP Practice |  | Date of 4 week follow up |  |
| Plans for managing withdrawal? | Heath trainer |  | CO measurement (mmol/l) |  |
| Not referred |  | GP Name |  |
| Client suitable for Champix (**Medical form Completed**) (Y/N) |  | If excluded please give reason? (See PGD). |  |

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| **Champix Supply & Monitoring** |
| **Week 1** | Date: |
| Product Supplied |  | Quantity |  |
| Patient advice and counseling provided? (Y/N) |  | Patient Information leaflet provided? |  |
| GP Notification Letter Faxed |  |  |
| Prescription levy Status (Please indicated B-S as per FP10) |  | Levy Collected (Y/N) |  |
| Name of staff member delivering the service: |  |
| Notes: |
|  |
| **Week 3** | Date: |
| Product Supplied |  | Quantity |  |
| Notes |  | Champix still suitable? |  |
| Prescription levy Status (Please indicated B-S as per FP10) |  | Levy Collected (Y/N) |  |
| Name of staff member delivering the service: |  |
| Notes: |
|  |
| **Week 7** | Date: |
| Product Supplied |  | Quantity |  |
| Notes |  | Champix still suitable? |  |
| Prescription levy Status (Please indicated B-S as per FP10) |  | Levy Collected (Y/N) |  |
| Name of staff member delivering the service: |  |
| Notes: |
|  |
| **Week 11** | Date: |
| Product Supplied |  | Quantity |  |
| Notes |  | Champix still suitable?  |  |
| Prescription levy Status (Please indicated B-S as per FP10) |  | Levy Collected (Y/N) |  |
| Name of staff member delivering the service: |  |
| Notes: |

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| Patient Discharge (**Please tick (✓) relevant box)** |
| Reason for Discharge | Treatment Complete – Quit |  | Discharge date |  |
|  | Treatment Complete – Not Quit |  |  |
|  | Lost to Service |  |
|  | Other (State Reason) |  |