|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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:** | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **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 |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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 tick relevant 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? Eg NRT Type? | | Health trainer |  | CO measurement (mmol/l) |  | |
| Not referred |  | GP Name |  | |
|  |  | GP Practice | | |
|  |  |
| Client suitable for NRT | (Y/N) |  |  |

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| **NRT Supply & Monitoring** |  | | **Patient’s Name** |  | | | | |
| **Week 1** | | | | | | | | |
| Date Last Smoked | |  | | CO reading (mmol/l) | | |  | |
| NRT | | Product 1 | | Quantity | | | Product 2 | Quantity |
|  | |  | |  | | |  |  |
| Prescription levy Status (Please indicated B-S as per FP10) | | | |  | Levy Collected (Y/N) | | |  |
| Name of staff member delivering the service: | | | |  | | | | |
| Notes: | | | | | | | | |
|  | | | | | | | | |
| **Week 2** | | | | | | | | |
| Date Last Smoked: | |  | | CO reading (mmol/l) | | |  | |
| NRT | | Product 1 | | Quantity | | | Product 2 | Quantity |
|  | |  | |  | | |  |  |
| 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 Last Smoked | |  | | CO reading (mmol/l) | | |  | |
| NRT | | Product 1 | | Quantity | | | Product 2 | Quantity |
|  | |  | |  | | |  |  |
| Prescription levy Status (Please indicated B-S as per FP10) | | | |  | Levy Collected (Y/N) | | |  |
| Name of staff member delivering the service: | | | |  | | | | |
| Notes: | | | | | | | | |
|  | | | | | | | | |
| **Week 4** | | | | | | | | |
| Date Last Smoked | |  | | CO reading (mmol/l) | | |  | |
| NRT | | Product 1 | | Quantity | | | Product 2 | Quantity |
|  | |  | |  | | |  |  |
| Prescription levy Status (Please indicated B-S as per FP10) | | | |  | Levy Collected (Y/N) | | |  |
| Four Week Quit Achieved | | Yes/No | | Patient Referred | | Yes/ No /Where | | |
| Name of staff member delivering the service: | | | |  | | | | |
| Notes: | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | | |
| **Week 5&6** | | | | | | | | |
| Date Last Smoked |  | CO reading (mmol/l) | | | | |  | |
| NRT | Product 1 | Quantity | | | | | Product 2 | Quantity |
|  |  |  | | | | |  |  |
| Prescription levy Status (Please indicated B-S as per FP10) | |  | | Levy Collected (Y/N) | | | |  |
| Name of staff member delivering the service: | |  | | | | | | |
| Notes: | | | | | | | | |
|  | | | | | | | | |
| **Week 7&8** | | | | | | | | |
| Date Last Smoked |  | CO reading (mmol/l) | | | |  | | |
| NRT | Product 1 | Quantity | | | | Product 2 | | Quantity |
|  |  |  | | | |  | |  |
| Prescription levy Status (Please indicated B-S as per FP10) | |  | | Levy Collected (Y/N) | | | |  |
| Name of staff member delivering the service: | |  | | | | | | |
| Notes: | | | | | | | | |
|  | | | | | | | | |
| **Week 9&10** | | | | | | | | |
| Date Last Smoked |  | CO reading (mmol/l) | | | |  | | |
| NRT | Product 1 | Quantity | | | | Product 2 | | Quantity |
|  |  |  | | | |  | |  |
| Prescription levy Status (Please indicated B-S as per FP10) | |  | | Levy Collected (Y/N) | | | |  |
| Name of staff member delivering the service: | |  | | | | | | |
| Notes: | | | | | | | | |
|  | | | | | | | | |
| **Week 11&12** | | | | | | | | |
| Date Last Smoked |  | CO reading (mmol/l) | | | |  | | |
| NRT | Product 1 | Quantity | | | | Product 2 | | Quantity |
|  |  |  | | | |  | |  |
| Prescription levy Status (Please indicated B-S as per FP10) | |  | | Levy Collected (Y/N) | | | |  |
| Name of staff member delivering the service: | |  | | | | | | |
| Notes: | | | | | | | | |
| Patient Discharge (**Please tick (✓) relevant box)** | | | | | | | | |
| Reason for Discharge: | Treatment Complete – Quit | |  | | Discharge date | | |  |
| Treatment Complete – Not Quit | |  | |  | | |  |
| Lost to Service | |  | |  | | |  |
| Other (State Reason) | |  | |  | | |  |

**Please note a copy of this form must be completed and retained in the pharmacy for every service user/patient – Form revised December 2015 (AJM)**