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| **Specialist Advisor Name**  **Specialist NHS Stop Smoking Service Monitoring Form 2014-15** | | | | | | | | | | | | | | | | | **Clinic Venue** | | | | | | | | | | | | | | | **Setting** | | | | | | | | | | | |
| Community | | | | | | |  | Community (MH) | | |  |
| **Secondary Care** | | | Hospital No: | | | | | | | | | | | | | | | | Hospital Name: | | | | | | | | | | | | | Hospital | | | | | | |  | Hospital (MH) | | |  |
| Consultant: | | | | | | | | | Speciality: | | | | | | | | | | | | | Ward: | | | | | | | | | | Maternity | | | | | | |  | Children’s Centre | | |  |
| **Please Circle:** | | IP | | OP | | | | PRE OP | | | | | Other | **Hospital Staff** – Yes / No | | | | | | | | | | | **Declined** – Yes / No | | | | | | | School/College/Uni/Workplace | | | | | | |  | GP / Pharmacy (please circle) | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Client Name** | | | | | | | | | | | **Telephone** *Tick preferred contact number* | | | | | | | | | | | | **Ethnic Group** | | | | | | | | | | **Occupation** | | | | **How did you hear about the service?** | | | | | | |
| Tel No  Mobile | | | | | | | | | | | | White | | | A British B Irish C Other White | | | |    | | | Managerial/Professional | |  | | GP | | | | |  | |
| Intermediate | |  | | Pharmacy | | | | |  | |
| **Client NHS Number** | | | | | | | | | | | Mixed | | | D White & Black Caribbean E White & Black African F White Asian G Other Mixed background | | | |     | | | Routine and Manual | |  | | Friend/family | | | | |  | |
| **Date of birth** \_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | | | | | Full time student | |  | | Midwife | | | | |  | |
| **Client Address**            **Postcode** | | | | | | | | | | | **Gender** Male  Female  | | | | | | | | | | | | Parent | |  | | District Nurse | | | | |  | |
| **Pregnant** Yes  No   If yes, due date \_\_\_/\_\_\_/\_\_\_\_\_\_ | | | | | | | | | | | | Asian or Asian British | | | H Indian J Pakistani K Bangladeshi L Other Asian background | | | |     | | | Retired | |  | | Other healthcare professional | | | | |  | |
| Home Carer (unpaid) | |  | | Health Worker | | | | |  | |
| **Medication currently taken**   |  |  |  |  | | --- | --- | --- | --- | | Theophylline |  | Insulin |  | | Clozapine |  | Warfarin |  | | Olanzapine |  |  |  | | | | | | | | | | | | | Long term sick/Disabled | |  | | Children Centre | | | | |  | |
| Black or Black British | | | M Caribbean N African P Other Black background | | | |    | | | Long term unemployed | |  | | Radio | | | | |  | |
| OR write occupation below: | | | | Newspaper | | | | |  | |
| **GP Surgery**  **Name of GP** | | | | | | | | | | | | | | | | | | | | | | | Other Ethnic Groups | | | R Chinese S Other Ethnic Group Z Not Stated | | | |    | | | …………………………………………… | | | | Other (specify | | | | |  | |
| **LGBT Question box** | | | | | | | | | | |
| **Are you currently suffering from or taking medication for a diagnosed mental health condition?** Yes  No  | | | | | | | | | | | | | | | | | | | | **Are you entitled to free prescriptions?** | | | | | | | | **Are you a Gypsy or Traveller?** | | | | |
| If yes, what medication are you taking…………………………………………………… | | | | | | | | | | | | | | | | | | | | Yes  No  | | | | | | | | Yes  No  | | | | |
| **Do you smoke** | | | | | | | | | | **Do you normally pay full price?** | | | | | | | | | | | | **Does anyone smoke inside your home?** | | | | | | | | | | | **Smoking History** | | | | | | | | | | |
| Straights Roll-ups Both  | | | | | | | | | | Yes  No  | | | | | | | | | | | | Yes  No  | | | | | | | | | | | Age stated smoking……………… | | | | | Number smoked per day……………. | | | | | |
| **Agreed Quit Date** \_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | | | | | | | | | **Current CO reading …………………………………..** | | | | | | | | | | | | | | | | | First time to cigarette…………………………………………………………………….. | | | | | | | | | | |
| **Product(s) used to assist quit** (tick **all products** that apply in this quit attempt) | | | | | | | | | | | | | | | | | | | | | | | | | | | NRT – Gum | | | | 🞏 | | **Quit Details**  *Please note you must attempt at least 3 times to follow up client for quit outcome* | | | | | | | | | | |
| NRT – Patch | | | | | | 🞏 | NRT – Nasal Spray | | | | | | | | 🞏 | | | NRT – Inhalator | | | | | | 🞏 | | | NRT – Microtab | | | | 🞏 | | **Has client quit smoking after 4 weeks?** | | | | | | | | | | |
| NRT – Mini-Lozenge | | | | | | 🞏 | NRT – Lozenge | | | | | | | | 🞏 | | | NRT – Mouth spray | | | | | | 🞏 | | | NRT – Oral Strips | | | | 🞏 | | Yes  | No  | | Unknown  | | | | | Did not set QD  | | |
| Zyban | | | | | | 🞏 | E-cigarette | | | | | | | | 🞏 | | | Champix | | | | | | 🞏 | | | None | | | | 🞏 | | **Date of last cigarette** \_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | | | |
| **When more than one product is ticked did the patient use the products:**  At the same time 🞏 One after the other (i.e. swapped products) 🞏 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **If client has quit smoking –** CO reading at 4 week follow up ………………. | | | | | | | | | | |
| **Type of support Given** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **If no reading recorded** have 3 attempts been made to contact client for CO reading? Yes  No  | | | | | | | | | | |
| Telephone🞏 | 1:1🞏 | | | | Drop-in clinic🞏 | | | | | | | Open (rolling) group 🞏 | | | | | | | | | Couple/Family🞏 | | | | Group 🞏 | | | | Closed Group 🞏 | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| Session Diary | | | | | **Why Public Health Collects This Information**  **Information for Client Consent to Service Monitoring**  Information is required by the Department of Health to measure how successful the Local Stop Smoking Service is in helping people to quit smoking. The information that will be gathered is entered on the monitoring form, which your Smoking Adviser uses and which he/she will show you.  There are several reasons for collecting this information:  **Your name, address and phone number –** Your details will be kept by NHS Devon on a database so that we may contact you again in the future, with your permission, to see if you have stopped smoking. Your postcode will enable us to see if smokers from all parts of Devon are using the service.  **Your age, gender, occupation and ethnic group –** This will help us to know if we are reaching all groups of smokers across Devon. Where employed please indicate your occupation so we can identify whether we are targeting manual and non-manual groups. If you are recently unemployed please put occupation held in last 12 months. The Department of Health requires us to record your ethnic group.  **Whether you are pregnant –** We want to know how many pregnant smokers are using the service, as this is a high national and local priority.  Your information will be entered into our database and anonymised and aggregated data will be used to produce figures for service evaluation and for submission to the Department of Health. This database will be held at Public Health, Devon County Council, County Hall, Exeter EX2 4QL.  Before this information can be collected, your consent is required. If you do not wish for this information to be forwarded to the Department of Health, you are under no obligation to sign the consent form. Your access to help and support and medical treatment will be unaffected.  **Client Consent/Data Protection Act – please read**  I agree to allow the data collected to be used by the local NHS Stop Smoking Service and other Government departments for analysis purposes in line with the requirements of the Data Protection Act 1998. Summary data, **which will be anonymous**, will be forwarded to the Department of Health for quarterly and annual evaluation.  I agree to the local NHS Stop Smoking Service contacting me after entering the service to confirm my non-smoking/smoking status.  I agree to allow the data to be viewed by a third party to aid in the processing of the data. I have been made aware that the personal data will not be presented to any direct marketing organisations for commercial use. |
| Please use the space below to make notes on specific support information. This can include medication requested, side effects experienced, withdrawal symptoms and the advice given regarding these points. Please do not use this as a quit diary. | | | | Fagerstrom  Score  ……………………………. |
| Session Date | Comments | Medication Request Notes  (including strength) | CO Reading | Advisor |
|  |  |  |  |  |
| **Client Consent to Monitoring -** Under the legislation of the Data Protection Act 1998, I agree to allow the data to be used by the NHS Stop Smoking Service and other government departments for analysis purposes. **I consent to the following: Treatment  Follow up by Stop Smoking Service Outcome sent to GP ** | | | | | |
| Name: Date: Signed\* \*or tick by adviser if client verbally consented over phone | | | | | |