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***PHARMACY SMOKING CESSATION***

***MONITORING FORM 2017/18***

**All shaded sections MUST be completed. Smoking cessation contract only enables payment for a fully completed form.**

**Smoking Cessation Monitoring Form 2017/18**

**Occupation**

**Ethnic Group**

**Fagerstrom Score…….**

1:1  Couple/family

Telephone Support

**Type of support given**

**GP surgery**

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Mobile**

**Address**

**Postcode**

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Date of Birth**

**Surname**

**First Name**

Long term unemployed  Home Carer (unpaid)  Managerial/ Professional

Intermediate  Routine & Manual  Retired

Long term sick/disabled  Student – full time  Not stated

**Gender**

Male  Female

Pregnant

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Landline**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **White**  British  Irish  Other white | **Mixed**  White & Black Caribbean  White & Black African  White Asian | **Asian or Asian British**  Indian  Pakistani  Bangladeshi  Other Asian background | **Black or Black British**  Caribbean  African  Other Black background | **Other Ethnic Group**  Other Ethnic Groups  Chinese  **Other**  Not stated |

Used instead of licensed medication

Used at the same time as licensed medication

Used consecutively to licensed medication (i.e. the client switched use as part of a single quit attempt but not used at the same time)

**Advisor Details:** I confirm that the information given on this form is true and complete.

**Advisor*****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**Client Consent to Monitoring -** Under the legislation of the Data Protection Act 1998, I consent to treatment and to allow the data collected to be used by the Stop Smoking Service and Public Health, Devon. Summary, anonymised data will be forwarded to the Department of Health for analysis.

I agree to the Stop Smoking Service contacting me to follow up my smoking status after treatment

I consent to the sharing of outcome data with my GP and/or referrer

**Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| Yes |  |
| No |  |
| Unknown |  |

CO Reading not taken

CO reading at 4 week follow up

**Has the client quit smoking after 4 weeks?**

**Type of products used**

Yes  No

**Unlicensed NCP (e.g. unlicensed e-cigarette used)**

**If yes, was this:**

**Use of unlicensed nicotine containing product (NCP)**

Patch  Gum  Nasal Spray

Lozenge  Inhalator  Microtab

**Mouth Spray**  **Oral Strips (Products in bold not funded by PH)**

Single NRT  Combination NRT  None

Champix  Zyban  Unknown

**Product used to assist Quit**

**When more than one pharmacotherapy has been used were they:**

Used at the same time  Used consecutively (one after the other)

**NRT products used** (only complete if the client used either single or combination NRT)

**Type of licensed pharmacological support used**

**This form is provided as an aide memoire only. Please retain in the Pharmacy and use to input data to Pharmoutcomes. You may also wish to record appointment dates to use the Pharmoutcomes SMS facility.**

**Entitled to free prescriptions**

Yes

No

*\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_*

**Agreed Quit Date**