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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**