Appendix 2

Varenicline Clinical Risk Assessment Form

Pharmacy Stamp	Client name: Address: Telephone number: Date of birth: GPs name & address:

Factor	Yes	No	Notes
Is client under 18 years of age			If ' yes' - refer
Is client pregnant or breastfeeding?			If ' yes' – refer`
Does client suffer from renal impairment or has end stage renal disease?			If ' yes'- refer
Does client have a history of psychiatric illness (Please refer to PGD)			If ' yes' - refer
Does client suffer from epilepsy?			If ' yes' - refer
Is client currently on another smoking cessation therapy?			If ' yes' - refer
Is client on any other medication?			Please list. Check PGD for interaction
Is client hypersensitive to varenicline or any of its excipients?			If ' yes' - refer

Special circumstances and any other relevant notes:

Only make a supply if you are certain that to the best of your knowledge, it is appropriate to do so.

Action taken:

Supply:

Referral to:

Advice given:

The above information is correct to the best of my knowledge. I have been counselled on the use of varenicline and understand the advice given to me by the pharmacist. **Client's signature:** Date	The action specified was based on the information given to me by the client, which, to the best of my knowledge, is correct **Pharmacist's signature:** Date: