Alberta Health Services

Patient label placed here (if applicable) or if labels are not used, minimum information below is required.

Name *(last, first)*
Birthdate *(yyyy-Mon-dd)*
Gender
Personal Health Number

Tobacco Dependence and Cessation Consult

Complete the Tobacco Dependence and Cessation Brief Intervention form *(#18251)* prior to this consult.

This consult to be completed for all patients requiring further behavioural support.

Are you having or have you had any nicotine withdrawal symptoms*? (e.g. Irritable, nervous, restless, trouble concentrating, trouble sleeping, depressed, increased appetite)*

☐ No ☐ Yes, action taken _____

Pattern of Use

Type of tobacco used (*check all that apply)*

☐ Cigarette ☐ Cigar/cigarillo ☐ Pipe ☐ Chew/spit

☐ Waterpipe *(e.g. Hookah)* ☐ Other *(specify)* _____

Current pattern of use *(amount, frequency, last use, how soon after waking)*	**Historical patterns** *(amount, frequency, number of years)*	**Exposure to second-hand smoke** ☐ At home ☐ Live in multi-family dwelling ☐ In the car ☐ Not exposed ☐ Other (*specify)*_____

Previous Treatment

Quit attempts *(last attempt, length of time, total number of quit attempts, longest quit)*

Past Relapse	**Cessation Medications**	**Behavioural Supports**	**Alternative Treatments**
☐ Discharge from healthcare site	☐ Nicotine Gum	☐ Group counselling	☐ Acupuncture
☐ Withdrawal symptoms	☐ Nicotine Inhaler	☐ Individual counselling	☐ Herbal remedies
☐ Stopped medication	☐ Nicotine Lozenge	☐ Self help materials	☐ Hypnosis
☐ Stopped behavioural support	☐ Nicotine Patch	☐ Online support	☐ Other (*specify)*_____
☐ Use of alcohol, other drugs	☐ Nicotine Mouth Spray	☐ Other (*specify)*_____	**No Treatment**
☐ Household smoker	☐ Bupropion SR		☐ Cold turkey
☐ Family/friends smoke	☐ Varenicline		☐ Tapering down
☐ Stress	☐ Other (*specify)*_____		
☐ Other (*specify)*_____			

Comments *(Include perceived effectiveness of previous treatment or approaches)*

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Information on Current Use

What are the good things about your tobacco use?

What are the not so good things?

Barriers/Concerns about quitting

- ☐ Withdrawal/Cravings
- ☐ Enjoyment
- ☐ Stress/Stress relief
- ☐ Discouragement/Lack of willpower
- ☐ Work environment
- ☐ Not ready
- ☐ Fear of failure
- ☐ Weight gain
- ☐ Cost of medication
- ☐ Cost/Timing groups
- ☐ Home environment
- ☐ Disruption of social relations
- ☐ Loss time to self/ Breaks
- ☐ Other *(specify)*_____

Stressors

- ☐ Financial
- ☐ Work or unemployment
- ☐ Family
- ☐ Mental illness
- ☐ Physical illness
- ☐ Housing
- ☐ Other (*specify)*_____

Triggers/Concerns about relapse

- ☐ Other smokers in the home
- ☐ Dealing with stress
- ☐ At work
- ☐ Social events
- ☐ Other (*specify)*_____

Readiness to Change

Which statement describes how you feel about your tobacco use

- ☐ I have quit smoking and I will never smoke again
- ☐ I have quit smoking, but I worry about slipping back
- ☐ I still smoke but I have begun to change and I'm ready to set a quit date
- ☐ I definitely plan to quit smoking within the next 30 days
- ☐ I definitely plan to quit smoking in the next 6 months
- ☐ I sometimes think about quitting smoking, but I have no plans to quit
- ☐ I enjoy smoking and have no interest in quitting for my lifetime

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✓	Not at all	Slightly	Moderately	Considerable	Extremely
Recently, how concerned have you been by your tobacco use?					
How important is it to change your tobacco use right now?					
How confident are you that you can make these changes?					
Health Care Provider rating of importance of treatment at this time.					

Comments

Treatment Plan *(patient/care provider/family mutually agreed upon goals and actions)*

What would you like to do next? How can I help you?

Date *(yyyy-Mon-dd)*	**Goal** *(reduce, quit, other, including time frame)*	**Action/Tasks/Activities to achieve goal**	**Response/Progress**	**Initials**

Plan for leaving healthcare site *(Refer to Tobacco Dependence and Cessation Brief Intervention - form #18251)*

Health Care Providers Name *(print)*	Signature	Date *(yyyy-Mon-dd)*	Time *(hh:mm)*