

COMMUNITY PHARMACY SMOKING CESSATION SERVICE

FOR OFFICE USE ONLY Pharmacy ID number:

TO BE COMPLETED BY THE CLIENT

Name: NICK O'TEEN

Date of birth: 1 / 12 /1970

Male Female

If you are female, are you pregnant?
 YES NO UNKNOWN

WHICH OF THE FOLLOWING BEST DESCRIBES YOUR ETHNIC ORIGIN ?

(choose one section from A – F, and then tick one box only within that section)

A - White

Scottish
English
Welsh
Northern Irish
British
Irish
Gypsy/Traveller
Polish
Any other ethnic group
(please specify)

B - Mixed or multiple ethnic groups

Any mixed or multiple ethnic groups
(please specify)

C - Asian, Asian Scottish or Asian British

Pakistani, Pakistani Scottish or Pakistani British
Indian, Indian Scottish, Indian British
Bangladeshi, Bangladeshi Scottish, Bangladeshi British

Chinese, Chinese Scottish, Chinese British
Other
(please specify)

D – African, Caribbean, or Black

African, African Scottish, African British
Caribbean, Caribbean Scottish, Caribbean British
Black, Black Scottish, Black British

Other
(please specify)

E- Other Ethnic background Arab Other (please specify)

F- Not disclosed

Do you receive free prescriptions? Yes No Unknown

EMPLOYMENT STATUS (please tick one box)

In paid employment Homemaker/full-time parent or carer Unemployed Not known/missing
 Retired Permanently sick or disabled Other (please specify)
 Full-time student

PERSONAL DETAILS

Address – 1 FIRST STREET ANYTOWN	Home telephone- 0131 0000 0000
Postcode- AA1 1AA	Mobile telephone- 07929 000000
	E-mail address- NICKOTEEN@MAIL.COM

TOBACCO USE AND QUIT ATTEMPTS

On average how many cigarettes do you usually smoke per day?

10 or less
 11 – 20
 21 – 30
 More than 30
 unknown

How soon after waking do you usually smoke your first cigarette?

Within 5 mins
 6 – 30 mins
 31 – 60 mins
 After 60 mins
 unknown

How many times have you tried to quit smoking in the past year?

No quit attempt
 Once
 2 or 3 times
 4 or more times
 unknown

PLEASE SIGN THE CONFIDENTIALITY STATEMENT OVERLEAF 

**TO BE COMPLETED BY THE PHARMACIST
INTERVENTION DETAILS**

Date referred to service: 1 DECEMBER 2010

Date of initial appointment: 7 DECEMBER 2010

Quit date: 14 DECEMBER 2010

INTERVENTION(S) USED

Product(s) used

NRT only (single product) NRT only (more than 1 product) None
& weeks used: 4

Type of intervention (tick all that apply)

One to one sessions Telephone support Other (please specify) _____

4 WEEK FOLLOW-UP

Was the client successfully contacted for 4 week follow up?

Yes No (Client did not consent to follow up) No (Client lost to follow up) No (Client died) Unknown

Date follow up carried out: 10 JANUARY 2011

Client withdrawn from service at time of follow up? Yes

Has the client smoked at all (even a puff) in the last 2 weeks? Yes No Unknown

CO reading confirms quit? Yes No CO reading not taken

Name of pharmacist: A. Pharmacist
Signature:

This form should be sent to (note: pharmacy to retain copy for audit purposes):

YOUR NHS BOARD

SMOKING CESSATION SERVICE CONSENT

Please read and complete the following. Please ask if you would like any item to be explained. If you do not agree to any of the following, you are still entitled to receive treatment.

I am willing for my details to be kept on a confidential database and for anonymised information to be used to assess how the stop smoking programme is working. YES NO

I agree to be contacted in the future in connection with my smoking (at 4 weeks, 3 months and 12 months). YES NO

How would you prefer to be contacted: Phone Post Email

DATA CONFIDENTIALITY AND SECURITY (To be signed by the client)

The information provided by you will be held in a secure environment in accordance with The Data Protection Act 1998. The information will only be used to assess the outcome of this project and no details will be passed on to any organisations who are not involved in the outcome assessment.

Signature N. O'Teen

Date ...21.../...1.../20..!!.....