



Break the Habit

A Pharmacist's Toolkit for Smoking Cessation Counselling

Follow-Up Assessment Form

Date of Assessment: _____

Patient Information

First Name: _____ Last Name: _____

Date of Birth: _____ City/Province: _____

Address: _____ Postal Code: _____

Phone: _____ Email: _____

Method of Contact ☐ In person ☐ Telephone ☐ Video conferencing ☐ Other: _____

Quit/Reduction Goal(s) ☐ Reduce ☐ Reduce to quit ☐ Quit Quit date: _____

Current Tobacco Use Status ☐ Not reduced ☐ Reduced by (amount per day): _____ ☐ Quit ☐ No change

Current Smoking Cessation Method

Non-Pharmacotherapy

☐ Reduce to quit ☐ Cold turkey ☐ Counselling including environmental changes, social support and distraction strategies

Pharmacotherapy					
Agent	Dosing and Frequency	Start Date	Adherence (Technique, Timing, Compliance)	Efficacy (Tobacco Status, Effect on Cravings)	Tolerability (Adverse Effects, Drug Interactions)
Nicotine Patch	Dose: ____ mg/day <input type="checkbox"/> 12hr <input type="checkbox"/> 16hr <input type="checkbox"/> 24hr				<input type="checkbox"/> Nausea <input type="checkbox"/> Dizziness <input type="checkbox"/> Vivid dreams <input type="checkbox"/> Insomnia <input type="checkbox"/> Skin irritation
Nicotine Gum	Dose: <input type="checkbox"/> 2 mg <input type="checkbox"/> 4 mg ____#/day <input type="checkbox"/> Scheduled <input type="checkbox"/> PRN				<input type="checkbox"/> Nausea <input type="checkbox"/> Dizziness
Nicotine Lozenge	Dose: <input type="checkbox"/> 1 mg <input type="checkbox"/> 2 mg <input type="checkbox"/> 4 mg ____#/day <input type="checkbox"/> Scheduled <input type="checkbox"/> PRN				<input type="checkbox"/> Nausea <input type="checkbox"/> Dizziness
Nicotine Inhaler	Dose: ____# of cartridges/day <input type="checkbox"/> Scheduled <input type="checkbox"/> PRN				<input type="checkbox"/> Nausea <input type="checkbox"/> Dizziness
Nicotine Spray	Dose: ____# of cartridges/day <input type="checkbox"/> Scheduled <input type="checkbox"/> PRN				<input type="checkbox"/> Nausea <input type="checkbox"/> Dizziness
Bupropion (Zyban)	Dose:				<input type="checkbox"/> Insomnia
Varenicline (Champix)	Dose:				<input type="checkbox"/> Nausea <input type="checkbox"/> Dizziness
Other (specify name):	Dose:				

See "Pharmacotherapy options," "NRT guidance for pharmacists" and "Non-NRT guidance for pharmacists" for additional pharmacotherapy monitoring information



Smoking Habits and Behavioural Strategies

Have you used any tobacco or tobacco-like products since we last spoke? ☐ Yes ☐ No

If yes, did you complete the smoking diary? ☐ Yes ☐ No

If yes, what were the circumstances in each relapse?						
Date	Time	Tobacco Product Used	# of Tobacco Products Used	Place	With Whom	Trigger

Note: If patient has a relapse, discontinue nicotine replacement therapy until patient is ready to quit again, encourage patient to reset a quit date, discuss possible reasons for relapse and help patient strategize about how to be more successful with the next quit attempt. Be empathetic and avoid scolding the patient.

- What has been the biggest challenge(s) for you since we last spoke? How have you handled the situation(s)?
- What is your plan to deal with high-risk situations (e.g., holidays, not smoking in the car, going out for a drink with a friend, going to a funeral)?
- What, if anything, are you most worried or concerned about related to your cessation efforts?

Cravings and Symptoms of Nicotine Withdrawal*

Assessed at: ☐ 0-2 weeks ☐ 2-4 weeks ☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months
☐ 18 months ☐ 24 months ☐ Other: _____

Symptom	Intensity (0 = not at all, 10 = completely)	Frequency (rare or less than daily, occasionally or 1-2x/day, frequently)	Triggers (e.g., morning routine, stress, environment, alcohol)
Desire to smoke (cravings)			
Cough			
Cold hands/feet			
Constipation			
Shortness of breath			
Phlegm production			
Anxiety/low mood			
Irritability			
Increased eating/weight gain			
Sweating			
Dizziness/headache			
Difficulty concentrating/ restlessness			
Trouble sleeping			
Stress			
Other			

*List of monitoring parameters is not exhaustive. Parameters should be tailored to individual patient.

Care Plan

Provide "NRT guidance for patients" and "Non-NRT guidance for patients," if required.

Program Withdrawal

At any time after the first consultation, a patient may decide to withdraw from the program, whether successful or not. The pharmacist should inform the patient who has withdrawn and who was not successful in quitting of their eligibility to re-enrol later. Should this occur, the pharmacist is asked to re-evaluate the patient's quit status.

☐ Patient has withdrawn from the smoking cessation program.

Next Follow-Up

Date: _____ Time: _____

Contact Method: ☐ In person ☐ Telephone ☐ Video conferencing ☐ Text

Permission to leave message: ☐ Yes ☐ No

Other: _____

FOR PHARMACIST USE ONLY

[Insert/Stamp Pharmacy Information Here]

Pharmacist Name: _____ Pharmacist License #: _____

Phone: _____ Fax: _____

Pharmacist Signature: _____

To be filed for documentation and auditing purposes in accordance with provincial legislation.

References

1. Petrasko K, Reeve C. *Smoking cessation* [internet]. May 1, 2018. Available from <https://cps.pharmacists.ca>. Subscription required.
2. Selby P, deRuiter W. *Tobacco use disorder: smoking cessation* [internet]. May 12, 2021. Available from <https://cps.pharmacists.ca>. Subscription required.
3. Pharmacists Manitoba. (2024). *Form 1: readiness to quit* [PDF file]. Available from: https://pharmacistsmb.ca/docs/SIBReadinesstoquitform_FillablePDF.pdf.