Break the Habit

A Pharmacist's Toolkit for Smoking Cessation Counselling

Readiness to Quit Smoking

Clear Form

Date of Assessment: _____

Patient Information

First Name: _____ Last Name: _____

Date of Birth: _____ City/Province: _____

Address: _____ Postal Code: _____

Phone: _____ Email: _____

Primary Care Provider Information

Name: _____ Phone: _____ Fax: _____

Readiness Assessment

ASK

1. Do you currently smoke or use any other forms of tobacco? Yes ○ No ◉
   If yes, how many cigarettes or other products do you smoke/use per day?_____
2. Do you feel ready to quit smoking? Yes ○ No ◉
3. Would you be willing to talk for a few minutes about your smoking? Yes ○ No ◉
4. If yes, are you willing to set a quit date within the next 30 days? Yes ○ No ◉

If yes, please provide a potential quit date:_____

ADVISE

Encourage a patient who smokes to quit in a way that shows empathy and reserves judgment. Let them know the benefits of quitting smoking, and tailor the quit smoking message based on their individual risk, needs and situation.

See "Risks of smoking and benefits of quitting."

ASSESS READINESS TO QUIT SMOKING

Given everything going on in your life right now, please answer the following questions on a scale from 1 to 10.

1. How **important** is it for you to quit smoking for good?	1 (not at all)	2	3	4	5	6	7	8	9	10 (extremely)
2. How **confident** do you feel you will be able to quit smoking altogether?	1 (not at all)	2	3	4	5	6	7	8	9	10 (extremely)
3. How **ready** are you to quit within the next 30 days?	1 (not at all)	2	3	4	5	6	7	8	9	10 (extremely)
4. When would you like to **stop** using tobacco products by?	Quit date:									
5. What are your **motivations** for quitting smoking?	☐ Family/relationships ☐ Financial ☐ Improve general health ☐ Existing illness ☐ Other:_____									

See "Stages of change" for further details.

*If the patient scores below 7 for any response, consider using additional motivational interviewing techniques.

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.

If the patient has decided to enrol and is willing to set a quit date, the pharmacist may proceed with the initial consultation and patient consent forms.

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.