Smoking Cessation Medication Self-Screening Questionnaire

Name_____ Date of Birth_____ Age*_____ Date_____

Best Phone Contact Number:
Primary Care Provider:

Do you have health insurance? Yes / No Please list:

Social and Medical History:

Are you currently using Cigarettes? Yes / No

If yes, how many per day? _____ How many years? _____

Are you currently using smokeless tobacco only (chew, electronic)? Yes / No ***(IF YES: NOT ELIGIBLE FOR PROTOCOL)***

Do you have a planned quit date? Yes/No If yes, when? _____

Have you previously tried to quit smoking? Yes/No

If so, how many times? _____ Methods tried? _____

Have you previously tried to quit smoking using medication(s)? Yes / No

If medications were used, please list them and what happened:

Please list any medical problems or health conditions:

Allergies or sensitivities to medications? *Yes / No* If yes, list them here:

Are you taking any medications currently (including OTC/herbal/vitamins)? Yes / No If yes, list them here:

NAME OF MEDICINE	**STRENGTH**	**DIRECTIONS**

Are you interested in trying a specific medication for tobacco cessation?

☐ Nicotine products (gum, patch, spray, inhaler)
☐ Bupropion SR (eg. Zyban/Wellbutrin)
☐ Varenicline (Chantix)
☐ Bupropion + Nicotine Patch
☐ Unsure / No preference

Specific Medical History:

1	Are you under 18 years of age?	Yes □ No □
1	Are you pregnant or are you planning on becoming pregnant?	Yes □ No □
2	Do you have a history of seizures (also called epilepsy)?	Yes □ No □
3	Do you have, or have you ever had, an eating disorder (anorexia, bulimia)?	Yes □ No □
4	Do you have an history of mental illness or a psychiatric disorder? (examples include anxiety, depression, bipolar disorder, manic/depressive disorder, schizophrenia, etc).	Yes □ No □
5	Have you ever had any bad reactions to nicotine replacement therapy, bupropion (Zyban/Wellbutrin) or varenicline (Chantix)?	Yes □ No □
6	Are you currently taking (or taken within the past 14 days) any medications for depression called "MAO-inhibitors" which may include isocarboxazid (Marplan), phenelzine (Nardil), rasagiline (Azilect), selegiline (Emsam) or tranylcypromine (Parnate)?	Yes □ No □
7	Have you had a heart attack within 14 days or do you have any history of heart electrical problems (called "arrhythmias") or severe or worsening chest pains (called "angina")?	Yes □ No □
8	Do you have any known medical conditions or problems with your kidneys (called "renal impairment or failure") or your liver (called "hepatic impairment or failure")?	Yes □ No □
9	Have you recently stopped using any seizure medications or sedative medications (also called barbiturates or benzodiazepines) or planning to stop using them?	Yes □ No □
10	Have you recently abruptly stopped using alcohol or planning to stop using alcohol?	Yes □ No □

Internal use only

☐ Verified patient DOB (with valid Colorado photo ID)

☐ BP reading: ___/____BP reading: ___/___

☐ Patient Not Eligible (Due to Line Item # above _____)

☐ Medication Prescribed per Protocol

Pharmacy name
Pharmacy address
Pharmacy Phone

Rx #:
Medication Prescribed:
Sig:

Pharmacist Prescriber Name:

Pharmacist Name and Signature

_____

Pharmacist Consultation

☐ 5 A's Utilized (Ask, Advise, Assess, Assist, Arrange) or 2 A's and 1 R (Ask, Advise, Refer)
☐ Medication Counseling Provided
☐ Quitline Referral Provided

Quit Date:_____

Follow-up Date and Plan:_____

_____
_____
_____

Additional Notes:

_____
_____
_____
_____
_____
_____
_____

***Attention Pharmacy**: This is a template document. Please feel free to customize it to your particular company, however you **must retain all elements** set forth by this template.*

FAX-TO-QUIT REFERRAL FORM

Date _____

COLORADO QuitLine™ Be tobacco free

Use this form to refer patients who are ready to quit tobacco or are thinking of quitting to the Colorado QuitLine.

PROVIDER(S): Complete this section

Provider name | Contact name

Clinic/Hosp/Dept | E-mail

Address | Phone ( ) –

City/State/Zip | Fax ( ) –

Does patient have any of the following conditions?

☐ pregnant ☐ uncontrolled high blood pressure ☐ heart disease

☐ **YES**, I authorize the QuitLine to send the patient over-the-counter nicotine replacement therapy.

Provider signature

A provider signature is required to authorize the QuitLine to dispense nicotine replacement therapy for patients with any of the above conditions.

Comments:

PATIENT: Complete this section

_____ *Initial* Yes, I am interested in quitting and ask that a QuitLine coach call me. I understand that the Colorado QuitLine will inform my provider about my participation.

Best times to call? ☐ morning ☐ afternoon ☐ evening ☐ weekend

May we leave a message? ☐ Yes ☐ No

Are you hearing impaired and need assistance? ☐ Yes ☐ No

Insurance? ☐ Yes ☐ No

Insurance carrier: _____

Member ID: _____

Medicaid? ☐ Yes ☐ No

Date of birth: / / Gender ☐ M ☐ F

Patient name (Last) (First)

Address | City | CO

Zip code | E-mail

Phone #1 ( ) – | Phone #2 ( ) –

Language ☐ English ☐ Spanish ☐ Other _____

Patient signature | Date

PLEASE FAX THIS PATIENT FAX REFERRAL FORM TO: 1-800-261-6259

Or mail to: Colorado QuitLine, National Jewish Health, 1400 Jackson St., M305, Denver, CO 80206