# Smoking Cessation Medication Self-Screening Questionnaire

**Name__________________________  Date of Birth ________  Age* ________  Date ________**

**Best Phone Contact Number:**  **Do you have health insurance?**  Yes / No  **Please list:**

**Primary Care Provider:**

**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:

<table>
<thead>
<tr>
<th>NAME OF MEDICINE</th>
<th>STRENGTH</th>
<th>DIRECTIONS</th>
</tr>
</thead>
</table>

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:**

<table>
<thead>
<tr>
<th></th>
<th>Are you under 18 years of age?</th>
<th>Yes □  No □</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Are you pregnant or are you planning on becoming pregnant?</td>
<td>Yes □  No □</td>
</tr>
<tr>
<td>2</td>
<td>Do you have a history of seizures (also called epilepsy)?</td>
<td>Yes □  No □</td>
</tr>
<tr>
<td>3</td>
<td>Do you have, or have you ever had, an eating disorder (anorexia, bulimia)?</td>
<td>Yes □  No □</td>
</tr>
<tr>
<td>4</td>
<td>Do you have an history of mental illness or a psychiatric disorder? (examples include anxiety, depression, bipolar disorder, manic/depressive disorder, schizophrenia, etc).</td>
<td>Yes □  No □</td>
</tr>
<tr>
<td>5</td>
<td>Have you ever had any bad reactions to nicotine replacement therapy, bupropion (Zyban/Wellbutrin) or varenicline (Chantix)?</td>
<td>Yes □  No □</td>
</tr>
<tr>
<td>6</td>
<td>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)?</td>
<td>Yes □  No □</td>
</tr>
<tr>
<td>7</td>
<td>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”)?</td>
<td>Yes □  No □</td>
</tr>
<tr>
<td>8</td>
<td>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”)?</td>
<td>Yes □  No □</td>
</tr>
<tr>
<td>9</td>
<td>Have you recently stopped using any seizure medications or sedative medications (also called barbiturates or benzodiazepines) or planning to stop using them?</td>
<td>Yes □  No □</td>
</tr>
<tr>
<td>10</td>
<td>Have you recently abruptly stopped using alcohol or planning to stop using alcohol?</td>
<td>Yes □  No □</td>
</tr>
</tbody>
</table>
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

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.
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**

<table>
<thead>
<tr>
<th>Provider name</th>
<th>Contact name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic/Hosp/Dept</td>
<td>E-mail</td>
</tr>
<tr>
<td>Address</td>
<td>Phone ( )</td>
</tr>
<tr>
<td>City/State/Zip</td>
<td>Fax ( )</td>
</tr>
</tbody>
</table>

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**

☐ Yes, I am interested in quitting and ask that a QuitLine coach call me. I understand that the Colorado QuitLine Initial 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 ____________________________________________________________________________

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

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