**SMOKING CESSATION COUNSELLING FORM**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of client:** |  | | **BIRTHDAY** |
| **Address:** |  | | **Age: \_\_\_\_\_\_\_ Sex:** |
| **Contact Number** |  | |  |
| **School:** | **Work:** | **Others:** | **Gender:** |
| **Status:** |
| Started Smoking at what age:  How long (number of years of smoking: | Smoker in the family? | How smoking started? | How many in a day (minimum and maximum)  Assess Nicotine Dependence (see back page) |
| Have you tried quitting? | Quitting experience | ADVISE: FIRST HAND (Effects of smoking to self) | ADVISE: SECOND AND THIRD HAND SMOKE: (Effects of smoking to others as observed by patient: |
| READINESS TO QUIT IN THE NEXT 30 DAYS? Make a plan ( Pre Contemplation, Contemplation, **Preparation, Action** and Maintenance/Relapse | | | |
| Set a quit date: | Tell families and friends:  Who and when to tell about the plan. Seek Help | Anticipate Challenges: | Remove tobacco: |
| NOT READY? (5 Ds’: Delay, Drink Water, Deep Breathing, District, Divine Intervention) | | | |
| Hindering factors for quitting | Risk Factors | Rewards (to include economic) Benefits of quitting | What would motivate you to stop |
| Re -assess readiness to quit | Negotiate and Plan |
| Recent Quitter – Prevent relapse (5R’s: Relevance, Risks, Rewards, Roadblocks, Repetition) | | | |
| Congratulate | Encourage | Discuss benefits | Address negative effects |
| FOLLOW-UP: (5R’s: Relevance, Risks, Rewards, Roadblocks, Repetition) | | | |
| CHECK UP THE PLAN IF ACHIEVED | FOLLOW UP AFTER 2 WEEK THEN MONTHLY | DIFFICULTIES | SUCESSES: |
| **COMMITMENT TO STAY TOBACCO FREE – Quit Contract** | | | |

We (name of patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and (name of treatment partner) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ agree to work together to help \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to quit smoking starting on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(date), following smoking free reasons:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s name and signature Health Worker’s name and signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment partner’s name and signature

**NICOTINE DEPENDENCE**

|  |  |  |  |
| --- | --- | --- | --- |
| **How soon after you wake up do you smoke your first cigarette?** |  | After 60 minutes | 0 |
|  | 31-60 minutes (1 mg) | 1 |
|  | 6-30 minutes **(2mg)** | 2 |
|  | Within 5 mins **(2mg)** | 3 |
| **Do you find it difficult to refrain from smoking in places where it is forbidden** |  | No | 0 |
|  | Yes | 1 |
| **Which cigarette would you hat it most to give up?** |  | The first in the morning | 1 |
|  | Any Other | 0 |
| **How many cigarettes per day do you smoke?** |  | 10 or less | 0 |
|  | 11-20 (1mg) | 1 |
|  | 21-30 (2mg) | 2 |
|  | 31 or more (2 mg) | 3 |
| **Do you smoke more frequently during the first hours after waking up than during the rest of the day?** |  | No | 0 |
|  | Yes | 1 |
| **Do you smoke even if you are ill that your in bed most of the day?** |  | No | 0 |
|  | Yes | 1 |
| **TOTAL SCORE** | | |  |

**Level of dependence on Nicotine (\_\_\_\_\_)**

|  |  |  |
| --- | --- | --- |
| 0 – No dependence | **5 - Medium dependence** | Refer for Nicotine Replacement Therapy if **score is 5-7** |
| 1-2 – Very Low Dependence | **6-7 High dependence** |
| 3-4 Low Dependence | **8-10 Very High dependence** |

Patient Medical History: ( *note: if one of the following is present NRT is not recommended*)

Cardiac Disease Recent Myocardial Infarction Irregular heart rate

Peptic Ulcer Disease Uncontrolled Hypertension Coronary Artery Disease

Treatment regimen: 1mg \_\_\_\_\_\_ or 2 mg\_\_\_\_\_\_\_\_\_\_

Date Treatment started: (mm/dd/yy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agreements and follow-up: Write exact date of start; patient to inform provider number of pastilles taken per day base on the client diary; indicate exact dates of follow-up

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Week**  **mm/dd/yy** | **Day 01** | **Day 02** | **Day 03** | **Day 04** | **Day 05** | **Day 06** | **Day 07** | **Follow-up Check up** | **Pastilles given** |
| 1 - |  |  |  |  |  |  |  |  |  |
| 2 - |  |  |  |  |  |  |  |  |  |
| 3 - |  |  |  |  |  |  |  |  |  |
| 4 - |  |  |  |  |  |  |  |  |  |
| 5 - |  |  |  |  |  |  |  |  |  |
| 6 - |  |  |  |  |  |  |  |  |  |
| 7 - |  |  |  |  |  |  |  |  |  |
| 8 - |  |  |  |  |  |  |  |  |  |
| 9 - |  |  |  |  |  |  |  |  |  |
| 10 - |  |  |  |  |  |  |  |  |  |
| 11 - |  |  |  |  |  |  |  |  |  |
| 12 - |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

Remarks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Name and Signature of Health Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_