14-Day Tobacco Treatment Follow-Up Form

Date: _____ Time: _____ Pharmacist's Name: _____

SECTION 1: PATIENT INFORMATION

Name (Last, First): _____ Date of Birth: _____ Quit Date: _____

SECTION 2: BEHAVIORAL ASSISTANCE

☐ Patient is enrolled with the Vermont Quitline (**1-800-QUIT-NOW**)

☐ Patient is participating in a group or web-based program

☐ Patient is receiving behavioral counseling at the pharmacy

☐ Other: _____

Does the patient feel they are getting sufficient help/support?

_____

What coping challenges have they had since the quit date? Cravings?

_____

SECTION 3: MEDICATION USE

Cessation medication(s) (name, strength) currently being used: _____

Date medication(s) were initiated: _____

Are the medication(s) being taken correctly? ☐ **Yes** ☐ **No** (describe below)

Is the patient experiencing any adverse effects due to the medication(s)? ☐ **Yes** ☐ **No** (describe below)

Are the patient's withdrawal symptoms being managed? ☐ **Yes** ☐ **No** (describe below)

Plans for terminating the medication(s):

SECTION 4: INTERVENTIONS

Describe what is working as well as any changes that are recommended.

Medication Regimen:

Behavioral Assistance Recommendations:

SECTION 5: PATIENT QUESTIONS AND CONCERNS

DOCUMENTATION

Complete the following and initial to the left of each requirement.

___ Discuss current medication use and modified regimen, if appropriate.

___ Discuss behavioral assistance and modified recommendations, if appropriate.

___ Document ongoing treatment plan.

___ Discuss plans for termination of medication(s).

___ Notify patient that you will contact them at the **end** of their medication regimen.

Date: _____ **ASK:** Preferred Contact # _____

___ Remind patient to follow-up with PCP at their next visit.