Final Tobacco Treatment Contact Form

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

SECTION 1: PATIENT INFORMATION

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

SECTION 2: CESSATION OUTCOMES

☐ Patient has successfully quit

☐ Patient quit but relapsed

Duration of quit attempt: _____

Reason(s) for relapse: _____

☐ Patient did not attempt to quit (did not stay off of tobacco for more than 24 hours)

☐ Patient is unable to be reached

Date of Contact Attempt #1: _____

Date of Contact Attempt #2: _____

SECTION 3: QUITTING STRATEGIES USED

Behavioral [Check All That Apply]

☐ Vermont Quitline (**1-800-QUIT-NOW**)

☐ Group or web-based program

☐ Behavioral counseling at the pharmacy

☐ Other: _____

☐ None

Does the patient feel they received sufficient help/support?

_____

Medication [Check One]

☐ No medication was provided

☐ Patient completed full duration of therapy

☐ Patient completed partial course of therapy

Duration: _____

Challenges: _____

Other: _____

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

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

Plans for terminating the medication(s):

SECTION 4: FUTURE PLANS

☐ **For tobacco-free patients:** Prevent relapse

☐ **For relapsed patients willing to try again:** Initiate a new quit attempt

☐ **For relapsed patients not willing to try again:** Establish future resources for when they are ready

Notes:

SECTION 5: PATIENT QUESTIONS OR CONCERNS

☐ None noted

☐ Questions/concerns discussed: