Patient Tobacco Treatment Plan Summary

PCP Name: _____ Phone Number: _____ Fax Number: _____

Dear Clinician: We have provided tobacco cessation treatment to your patient, as referenced below in Section 1. Please document this in his or her chart. We will meet with your patient again within the next two weeks (in person or via telephone, based on their preference), and again at the end of treatment and have advised him or her to follow-up with you. If you have questions, please contact us:

Pharmacy Name and Address: _____

Dispensing Pharmacist's Name: _____ Phone Number: _____

SECTION 1: PATIENT INFORMATION

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

Primary Phone Number: _____

SECTION 2: TREATMENT PLAN

- **MEDICATION 1 Dispensed (Name, Strength):** _____

  Dosing: _____

  The following were discussed with the patient:

  - ☐ Proper use, duration of drug therapy, drug storage
  - ☐ Techniques for self-monitoring of drug therapy
  - ☐ What to do if a dose is missed
  - ☐ Common adverse effects; how to avoid, and what to do if encountered
  - ☐ Refill information

If Applicable:

- **MEDICATION 2 Dispensed (Name, Strength):** _____

  Dosing: _____

  The following were discussed with the patient:

  - ☐ Proper use, duration of drug therapy, drug storage
  - ☐ Techniques for self-monitoring of drug therapy
  - ☐ What to do if a dose is missed
  - ☐ Common adverse effects; how to avoid, and what to do if encountered
  - ☐ Refill information

• **BEHAVIORAL COUNSELING PLAN:**

☐ Patient was advised to reduce caffeine intake (due to drug interaction with smoking)

Select one or more of the following:

- ☐ A fax referral was sent to the Vermont Quitline (**1-800-QUIT-NOW**)
- ☐ Patient was advised to call and enroll in the Vermont Quitline program
- ☐ Patient was referred to a group or web-based program
- ☐ Patient will be receiving behavioral counseling at the pharmacy

• **DATE CONTACTED PATIENT'S PCP:**

Date/time called or faxed: _____ If called, spoke with: _____ Initials: _____