AllHealth NETWORK Pharmacy

5500 S Sycamore St, Suite 100
Littleton, CO 80120-8201Phone - 303-797-2500Fax - 303-730-8730
www.allhealthnetwork.org/services/pharmacy

SMOKING CESSATION MEDICATION SELF-SCREENING QUESTIONAIRE

Patient Name ___________________________________ DOB____________ Age* ________ Date ______________

Phone ____ Email ____

Do you have health insurance? Yes / No Please list: ____

Social and Medical History:

Are you currently using Cigarettes? Yes / No If yes, how many per day? ____________ How many years? ___________

How soon do you smoke your first cigarette after waking up? Within 30 minutes? _____ More than 30 minutes? ______

Are you currently using smokeless tobacco <u>only</u> (chew, electronic)? Yes / No ***<u>(IF YES: NOT ELIGIBLE FOR PROTOCOL)</u>***

Do you have a planned quit date? Yes / No If yes, when? _________

Have you previously tried to quit smoking? Yes / No Last attempt date? ______________________

If so, how many times? ________________ Methods tried? ______________

Have you previously tried to quit smoking using medications(s)? Yes / No

If medications were used, please list them and what happened:
____
____
____

Have you or are you Registered with Quitline? Yes / No

Please list any medical problems or health conditions:
____

Allergies of 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:

NAME OF MEDICINE	STRENGTH	DIRECTIONS

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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:

1	Are you under 18 years of age?	Yes ☐ No
2	Are you pregnant or are you planning on becoming pregnant?	Yes ☐ No
3	Do you have a history of seizures (also called epilepsy)?	Yes ☐ No
4	Do you have, or have you ever had, an eating disorder (anorexia, bulimia)?	Yes ☐ No
5	Do you have a history of mental illness or a psychiatric disorder? (examples include anxiety, depression, bipolar disorder, manic/depressive disorder, schizophrenia, etc).	Yes ☐ No ☐
6	Have you ever had any bad reactions to nicotine replacement therapy, bupropion (Zyban/ Wellbutrin)	Yes ☐ No ☐
7	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	Yes ☐ No ☐
8	Have you had a heart attack within 14 days or do you have any history of heart electrical problems	Yes ☐ No ☐
9	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”)?	Yes ☐ No ☐
10	Have you recently stopped using any seizure medications or sedative medications (also called barbiturates or benzodiazepines) or <u>planning to stop</u> using them?	Yes ☐ No ☐
11	Have you recently abruptly stopped using alcohol <u>or planning to stop</u> using alcohol?	Yes ☐ No

Internal use only

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Rx#:
Sig:

Pharmacist Prescriber Name:

☐ 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 Date

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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:

____
____
____
____
____
____
____
____

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FAX-TO-QUIT REFERRAL FORM

Date ____________

Use this form to refer patients who are ready to quit tobacco in the next 30 days to the Colorado QuitLine.

PROVIDER(S): Complete this section

Provider name ____________ Contact name ____________

Clinic/Hosp/Dept ____________ E-mail ____________

Address ____________ Phone ( ) –

City/State/Zip ____________ Fax ( ) –

PLEASE INDICATE IF THE PATIENT HAS MEDICAID: ☐ YES ☐ NO

If yes, and you are prescribing tobacco cessation medication, please complete the Medicaid prior-authorization form on the back of this form and provide patient with a prescription. All FDA-approved tobacco cessation medications are available.

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

_____ *Initial* Yes, I am ready to quit and ask that a QuitLine coach call me. I understand that the Colorado QuitLine 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 ____________ E-mail ____________

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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