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Littleton, CO 80120-8201
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www.allhealthnetwork.org/services/pharmacy

SMOKING CESSATION MEDICATION SELF-SCREENING QUESTIONNAIRE

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 only (chew, electronic)? Yes / No ***(IF YES: NOT ELIGIBLE FOR PROTOCOL)***

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

NAME OF MEDICINE	STRENGTH	DIRECTIONS

Are you interested in trying a specific medication for tobacco cessation?

Nicotine products (gum, patch, spray, inhaler)

Bupropion + Nicotine Patch

Bupropion SR (eg. Zyban / Wellbutrin)

Unsure / No preference

Varenicline (Chantix)

Specific Medical History:

1	Are you under 18 years of age?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2	Are you pregnant or are you planning on becoming pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3	Do you have a history of seizures (also called epilepsy)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4	Do you have, or have you ever had, an eating disorder (anorexia, bulimia)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
6	Have you ever had any bad reactions to nicotine replacement therapy, bupropion (Zyban/Wellbutrin) or varenicline (Chantix)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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 (Parnate)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8	Have you had a heart attack within 14 days or do you have any history of heart electrical problems (called "arrhythmias") or severe or worsening chest pains (called "angina")?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
11	Have you recently abruptly stopped using alcohol <u>or planning to stop</u> using alcohol?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Internal use only

AllHealth Network Pharmacy
5500 S Sycamore St. #100, Littleton, CO 80120
303-797-2500

- Verified patient DOB (with valid Colorado photo ID)
- BP reading: ___/___ BP reading: ___/___
- Patient Not Eligible (Due to Line Item # above _____)
- Medication Prescribed per Protocol

Rx#:

Sig:

Pharmacist Prescriber Name:

Pharmacist
5500 S Sycamore St. #100
Littleton, CO 80120
303-797-2500

Date

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:

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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