

Smoking Cessation




Package of Care Number: _____

Surname _____	Given Names _____
NHI _____	Age _____
Ethnicity <input type="checkbox"/> NZ European <input type="checkbox"/> Maori <input type="checkbox"/> Pacific <input type="checkbox"/> Asian <input type="checkbox"/> European <input type="checkbox"/> Other	

Plan:

- Nicotine Replacement Therapy Medication

Complete relevant section below at each consultation

Initial Consultation	Follow Up
Date: _____ Cessation Consultation to be provided by <input type="checkbox"/> GP <input type="checkbox"/> Nurse <input type="checkbox"/> Other (Please state) i.e. Quitline, Aukati Kaipaipa etc.	1 week Date _____ <input type="checkbox"/> No change <input type="checkbox"/> Reduced <input type="checkbox"/> Abstinent 2 weeks Date _____ <input type="checkbox"/> No change <input type="checkbox"/> Reduced <input type="checkbox"/> Abstinent  4 weeks Date _____ <input type="checkbox"/> No change <input type="checkbox"/> Reduced <input type="checkbox"/> Abstinent 6 weeks Date _____ <input type="checkbox"/> No change <input type="checkbox"/> Reduced <input type="checkbox"/> Abstinent  3 months Date _____ <input type="checkbox"/> No change <input type="checkbox"/> Reduced <input type="checkbox"/> Abstinent 6 months Date _____ <input type="checkbox"/> No change <input type="checkbox"/> Reduced <input type="checkbox"/> Abstinent 12 months Date _____ <input type="checkbox"/> No change <input type="checkbox"/> Reduced <input type="checkbox"/> Abstinent 

I give consent for this information to be passed to Rural Canterbury PHO to be used in a non-identifiable manner for population based statistics.

 Patient Signature

FAX form to RCPHO office (03 357 4372) at initiation, 3 months, 6 months and 12 months.