Quit Smoking | PGD Risk Assessment Form

Date: _ _ / _ _ / 2 0 _ _

Patient's personal details	
Title: Mr: □ Miss: □ Ms: □ Mrs: □ Dr: □	Patient Address:
First Name:	NHS No. (if known):
Last Name:	GP Name and Address:
Telephone:	GP Telephone (if known):
Gender: Male: □ Female: □ D.O.B: ___ ___/ ___ ___ / ___ ___ ___ ___ Age:	Would you like us to send a copy of this consultation to your GP? □

Personal Medical History			
Tick which of the following applies to you…	***Yes***	***No***	***Details (reconfirm each appointment)***
Do you have any recent or past medical history of note?	☐	☐	
Have you had a serious reaction to a varenicline before?	☐	☐	
Have you received advice from a smoking cessation counsellor before?	☐	☐	
Have you tried to quit using nicotine replacement therapy (NRT) before?	☐	☐	
Are you on any medicines? Such as antiepileptics, antidepressants, antipsychotics, B-blockers, type 1C antiarrhythmics, cimetidine, theophylline or warfarin?	☐	☐	
Do you have a medical history of any of the following: renal / kidney problems, psychiatric illnesses (with symptoms of irritability or depression), myocardial infarction (MI) or risk factors for MI?	☐	☐	
Precautions			
Tick which of the following applies to you…	***Yes***	***No***	***Details (reconfirm each appointment)***
Do you understand that you must seek prompt medical advice if you develop agitation, depressed mood, or suicidal thoughts whilst taking varenicline?	☐	☐	
Do you understand that varenicline may affect your ability to perform tasks that require judgement or motor and cognitive skills?	☐	☐	
Motivation			
Tick which of the following applies to you…	***Yes***	***No***	***Details (reconfirm each appointment)***
Do you feel sufficiently motivated to quit smoking (willing to set a quit date between days 8 and 14 of starting treatment)?	☐	☐	
Do you agree to receive weekly face-to-face motivational support for the first four weeks at least?	☐	☐	
WOMEN ONLY			
Tick which of the following applies to you…	***Yes***	***No***	***Details (reconfirm each appointment)***
Are you pregnant or planning a pregnancy?	☐	☐	
Are you breastfeeding?	☐	☐	

Write below any further information which may be relevant e.g. medicines taking, conditions, concerns...

For Offical Use

Initial consultation

Date	Qty	Details	Pharmacist	Comment	Price
		Varenicline. *Days 1-3: 0.5mg once daily* *Days 4-7: 0.5mg twice daily* *Day 8 – end of treatment (12 weeks total): 1mg twice daily*			

Follow up...

Date	Qty	Details	Pharmacist	Comment	Price
		Varenicline. ***Day 8 – end of treatment (12 weeks total)**: 1mg twice daily*			

Additional smoking cessation advice					
Smoking	☐	PIL given?	☐	Lifestyle advice	☐
Side effects	☐	Alcohol	☐	Depression	☐

PATIENT CONSENT

I have received information on the risks and benefits of the medicines recommended and fully understand them. I have also had the opportunity to ask questions. I consent to the recommended medicines being given at each appointment*.

Patient Name / signature ..... **Date**.....

Do you consent for our pharmacy and/or our authorising medical agency to contact you regarding customer satisfaction? Yes / No

PHARMACIST AGREEMENT

I have consulted the specific PGD which enables me to supply the listed medicine and have found that the patient is included in treatment and there are no valid exclusions applicable. I have given the patient information on the risks and benefits of the medicines recommended and have done my utmost to ensure the patient fully understands them. I have also given the patient the opportunity to ask questions. This will be carried out at each appointment.

Pharmacist Name / signature ..... **Date**.....