AllHealth NETWORK
PHARMACY

5500 S Sycamore St, Suite 100
Littleton, CO 80120-8201
Phone - 303-797-2500
Fax - 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 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

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

☐ Nicotine products (gum, patch, spray, inhaler)
☐ Bupropion SR (eg. Zyban / Wellbutrin)
☐ Bupropion + Nicotine Patch
☐ Unsure / No preference

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☐ Varenicline (Chantix)

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) or varenicline (Chantix)?	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 (Parnate)?	Yes □ No □
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 □ 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 planning to stop using them?	Yes □ No □
11	Have you recently abruptly stopped using alcohol or planning to stop using alcohol?	Yes □ No □

Internal use only

☐ Verified patient DOB (with valid Colorado photo ID)

☐ BP reading: ___/____BP reading: ___/___

☐ Patient Not Eligible (Due to Line Item # above _____)

☐ Medication Prescribed per Protocol

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

Rx#:
Sig:

Pharmacist Prescriber Name:

_____ _____

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:

_____
_____
_____
_____
_____
_____
_____

FAX-TO-QUIT REFERRAL FORM

Date _____

COLORADO QuitLine™ Be tobacco free

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