SS2 - Level 3 Client Questionnaire & Consent Form

Version 8 January 2018

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf University Health Board

About You			
Title:	Mr / Mrs / Miss / Ms Other		
Full Name			
Address		**Postcode**	
Tel No:		**Email**	
Date of Birth		**Age**	
What is your ethnic group?			
Occupation			
GP Name:			
GP Practice Name & Address			

Medical history

Have you had or do you suffer from any of the following? (please tick all that apply)

☐	Angina	☐	Heart Attack	☐	High Blood Pressure	☐	Stroke
☐	Irregular heartbeat	☐	Diabetes	☐	Chest Problems	☐	Asthma
☐	Psoriasis	☐	Eczema	☐	Liver problems	☐	Kidney problems

Are you scheduled for any surgery in the next 8 weeks?	☐Yes	☐No
Are you pregnant or breastfeeding?	☐Yes	☐No
Are you taking any medication from your doctor?	☐Yes*	☐No

** if yes please take a list of your medication with you to the pharmacy*

Your Smoking History

What age did you start Smoking?		
Have you ever tried to stop smoking before?	☐Yes ☐No	
	If YES how many times	
Have you used nicotine replacement therapy/varenicline before?	☐Yes ☐No	
	What product(s) did you use?	
Have you used any other treatments to help you stop smoking?	☐Yes ☐No	
	What treatment did you use?	

To help decide which treatments will help you to stop smoking please answer the following questions as honestly as possible

How soon after you wake do you have your first cigarette?							
☐	Within 5 mins (3)	☐	6-30 mins (2)	☐	More than 30 mins (1)	☐	Over 60 minutes (0)

How many cigarettes do you usually smoke per day?							
☐	10 or less (0)	☐	11 to 20 (1)	☐	21 to 30 (2)	☐	31 or more (3)

Do you find it difficult not to smoke in places where it is forbidden?	☐ Yes (1)	☐ No (0)
Do you smoke more in the first hours after waking than during the rest of the day?	☐ Yes (1)	☐ No (0)
Which cigarette would you most hate to give up?	☐ First cigarette of the day (1) ☐ Any other cigarette during the day (0)	
Do you smoke when you are so ill that you are in bed?	☐ Yes (1)	☐ No (0)

Motivation: On a scale if 1 to 10 (10 being highest) how motivated are you to quit?									
☹									☺
1	2	3	4	5	6	7	8	9	10

Confidence: On the same scale how confident are you that you will quit?									
☹									☺
1	2	3	4	5	6	7	8	9	10

STOP SMOKING SERVICE: PATIENT CONSENT FORM

Consent to participate in the Stop Smoking Service: The pharmacy will keep a record of the service provided to you.

I agree that the information obtained during the service can be shared with:

- ☐ Cwm Taf University Health Board (LHB) to allow them to make sure the service is being provided properly by the pharmacy;
- ☐ Cwm Taf University Health Board (LHB) and the NHS Shared Services Partnership (SSP) to make sure the pharmacy is being correctly paid by the NHS for the service they give me;
- ☐ I agree for the pharmacy to contact me by telephone/text during my quit attempt;
- ☐ My doctor (GP) to help them provide care to me;
- ☐ I understand that my quit attempt will terminate 14 days after a missed appointment.

Patient Name:			
Patient Signature:		Date	

Pharmacy Use: Client accepted ☐ Yes ☐ No

NECAF Patient ID Number