

Smoking Cessation One-to-One Session Form

Tutor name	
Tutor location	

Patient name			
Date of birth		Age	
Address			
GP name			
GP practice			
Health problems			
Medication			

Smoking details	
How long has patient been smoking?	
Product smoked	
Number per day	
Time of first smoke	
Time of last smoke	
Smoke at night?	

Checklist of discussion with patient	
Explain smoking cessation service	
Treatment options (e.g. NRT, varenicline)	
Support booklet / resources	
Quit date	
Monitoring form returned at 4 weeks	
Monitoring form returned at 12 weeks	

Quit date:		4 weeks after quit date:	
Quit at 4 weeks?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> LOST TO FOLLOW UP

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Session	Date	CO	Comments	Medication supplied	Patient initials
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					