Hertfordshire Stop Smoking Service

NHS

DEPARTMENT OF HEALTH MONITORING FORM

Note: All patient data must be kept securely and in accordance with Caldicott guidelines. Information can only be passed to another healthcare professional if this contributes to the provision of effective care. Refer to guidance notes for assistance with the completion of the monitoring form.

Adviser details: Please print

Department/Ward ……
Name ……
Contact Tel. No. ……
Location/setting ……
Venue ……
Adviser code/ref ☐☐☐☐☐☐
PCT area ❑ E/N ❑ W

Client details: Please print

Surname ……
Address ……
……
Postcode ……
Daytime Tel. No. ……
First Name ……
(Mr/Mrs/Ms/Other)
NHS ID. No. ……
Mobile Tel. No. ……
Can a message be left, if someone else answers ❑ Yes ❑ No
Answerphone ❑ Yes ❑ No
Date of Birth …… **Age** (in years) ……
Gender ❑ Male ❑ Female
Exempt from prescription charge ❑ Yes ❑ No
Pregnant ❑ Yes ❑ No **Breast feeding** ❑ Yes ❑ No
GP practice name ……
GP code ☐☐☐☐☐☐

Occupation (please see guidance notes)

Student	❑	Managerial/professional	❑
Never worked/long term unemployed	❑	Intermediate	❑
Retired	❑	Routine and manual	❑
Sick/disabled and unable to work	❑	Unable to code	❑
Home carer	❑		

Ethnic group: Please tick relevant group

A) White		**B) Mixed**		**C) Asian or Asian British**	
British	❑	White and Black Caribbean	❑	Indian	❑
Irish	❑	White and Black African	❑	Pakistani	❑
Other white background	❑	White and Asian	❑	Bangladeshi	❑
		Other mixed groups	❑	Other Asian background	❑
D) Black or Black British		**E) Other Ethnic Groups**		**F) Other**	
Caribbean	❑	Chinese	❑	Not stated	❑
African	❑	Other ethnic group	❑		
Other black background	❑				

How client heard about the service: Please tick relevant box

GP	❑	Friend/relative	❑	Pharmacy	❑
Other health professional	❑	Advertising	❑	Other (specify)	❑
				……	

Type of intervention delivered: Please tick relevant box

Closed group	❑	Telephone support	❑	Other (specify)	❑
Open (rolling) group	❑	Couple/family	❑	……	
One to one support	❑	Drop-in clinic	❑		

Type of pharmacological support used: Please tick all relevant boxes

Use 1, 2 or 3 to indicate consecutive use of more than one medication e.g. NRT followed by Zyban and Champix

NRT - Patch	☐	NRT - Gum	☐	NRT - Lozenge	☐
NRT - Inhalator	☐	NRT - Microtab	☐	NRT - Spray	☐
None	☐	Zyban	☐	Champix	☐

Treatment outcome: Please tick relevant box

Quit CO verified ❑ Quit self report ❑ (quit not CO verified) Not quit ❑ Lost to follow up ❑

Agreed quit date …… **Date of last tobacco use** …… **Date of 4 week follow-up** ……

(Note: Quit is defined as not smoked at all in past 14 days. Clients are not considered to have failed if they smoke in the first few difficult days.)

ADVISER SIGNATURE

……

Print name ……

CLIENT SIGNATURE (indicating consent to treatment and follow-up and passing on of outcome data to GP)

……

Date ☐☐ ☐☐ ☐☐☐☐

Please return form to: **Hertfordshire Stop Smoking Service, Royalty House, 10 King Street, Watford, WD18 0BW Tel: 01923 281688 Fax: 01923 281633**
NOTE: Forms must be returned by each quarterly closing date as advised by the Hertfordshire Stop Smoking Service.