(Form 3: Follow-up)

Date of consult:	Patient name:	PHIN:
Address:	City & Province	Postal code:

Follow-up Record (check appropriate box)

Date:	Method: ☐ Call ☐ In-person ☐ Unable to reach (min 3 attempts)
Was this a mandatory consult? If yes, check accordingly.	☐ 6 month ☐ 12 month

Complete If This Is Either a 6 or 12 Month Follow Up

Quit Status Assessment at:	☐ 6 month	☐ 12 month
Has patient successfully *quit** tobacco products?	☐ Yes	☐ No

**Definition of 'quit' – Participant has sustained smoking cessation for a minimum of thirty (30) continuous days immediately preceding the date six (6) or twelve (12) months after their initial assessment.*

Medication Management

How have the medications been working out?

Agent	Side-effects	Effect on cravings	Frequency of use

Smoking Habits & Behavioral Strategies

Have you used any tobacco or tobacco-like products since we last spoke? ☐ Yes ☐ No

If yes, what were the circumstances in each slip-up?

Date & Time	# cigs	Place	With Whom	Trigger

What have been your biggest challenges since we last spoke? How have you handled them?

	Previous patient concerns	Alternative recommendations
1		
2		
3		
4		
5		

Were there any additional concerns that came up since we last spoke?

	Additional patient concerns	Recommendations
1		
2		
3		
4		
5		

Smoking Symptoms & Symptoms of Withdrawal						
0 = no symptoms, 5 = worst ever						
	0	1	2	3	4	5
Cough	☐	☐	☐	☐	☐	☐
Shortness of breath (exertion)	☐	☐	☐	☐	☐	☐
Shortness of breath (at rest)	☐	☐	☐	☐	☐	☐
Phlegm production	☐	☐	☐	☐	☐	☐
Cold hands/feet	☐	☐	☐	☐	☐	☐
Cravings	☐	☐	☐	☐	☐	☐
Irritability	☐	☐	☐	☐	☐	☐
Depressed mood	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐
Trouble concentrating	☐	☐	☐	☐	☐	☐
Trouble sleeping	☐	☐	☐	☐	☐	☐

Next Appointment		
Date of next follow-up	Week of:	
Preferred method	☐ Call	☐ In-person