

Tobacco Treatment Enrollment

Sponsored by the New Hampshire Department of Health & Human Services

Tobacco Treatment Checklist

- ADVISE** to stop: Stop-smoking advice given: "I strongly advise you to quit smoking and I can help you."
- ASSESS** readiness to quit: Ready to quit Thinking about quitting Not ready to quit
- ASSIST** to quit: Brief counseling
Reasons to quit Barriers to quitting Lessons from past quit attempts Set a quit date, if ready Enlist social support
- Medications if appropriate
Nicotine Replacement (CIRCLE): patch gum lozenge inhaler nasal spray
 Other (CIRCLE): Bupropion (Zyban®/Wellbutrin SR®) Varenicline (Chantix®)
- ARRANGE** follow-up: Refer to Try-To-STOP TOBACCO Resource Center
 by faxing the lower portion of this form toll-free to **1-866-560-9113**

Fax this part of the form to 1-866-560-9113

TRY-TO-STOP TOBACCO RESOURCE CENTER OF NEW HAMPSHIRE

New Hampshire Resident Enrollment Form

REFERRAL SOURCE/FOLLOW-UP CONTACT			
referred by	NAME _____ FACILITY _____ ADDRESS _____	phone (area code + number) ()	fax (area code + number) ()
follow-up report contact		phone (area code + number) ()	fax (area code + number) ()
PATIENT			
first name	last name	date of birth (month/day/year)	
phone (area code + number) ()	May we leave a message? <input type="checkbox"/> yes <input type="checkbox"/> no	language preference (check): <input type="checkbox"/> English <input type="checkbox"/> Spanish other (specify) _____	
email address			
client address	city	state	zip
primary insurance	<input type="checkbox"/> Anthem Blue Cross/Blue Shield <input type="checkbox"/> Cigna <input type="checkbox"/> Harvard Pilgrim <input type="checkbox"/> Tufts <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Delta Dental <input type="checkbox"/> Health Trust <input type="checkbox"/> Uninsured <input type="checkbox"/> Other		
THE RESOURCE CENTER USUALLY CALLS THE CLIENT WITHIN 3 BUSINESS DAYS OF RECEIVING A REFERRAL. WHEN SHOULD WE CALL?			
check all that apply:	<input type="checkbox"/> morning	<input type="checkbox"/> afternoon	<input type="checkbox"/> evening <input type="checkbox"/> no preference

I, _____, hereby authorize Try-To-STOP TOBACCO Resource Center of New Hampshire, (the "Resource Center"), and its representatives to disclose information about me to:

- 1) the JSI Quitline to the extent necessary to allow me to participate in its tobacco cessation counseling program; and
- 2) my primary care provider or other provider ("Provider") I designate to the Resource Center to the extent the Resource Center deems necessary to give my Provider an update of my progress in attempting to stop smoking.

I authorize my Provider to release the information on this enrollment form to the Resource Center for purposes of my participation in the QuitWorks-NH program. I also authorize the Resource Center and its representatives to contact me upon receiving this referral from my Provider.

SIGNATURE OF QUITWORKS-NH CLIENT OR CLIENT'S REPRESENTATIVE

DATE

PRINTED NAME OF QUITWORKS-NH CLIENT OR CLIENT'S REPRESENTATIVE

RELATIONSHIP TO CLIENT

QUITWORKSSM-NH

Quick Guide To Pharmacotherapy In Tobacco Treatment

NICOTINE REPLACEMENT OPTIONS

PATCHES

Nicoderm [®] CQ 7, 14, 21 mg	Initial: MAX:	1 patch/24 hrs. Same as above	Treatment Duration: 8–12 wks.
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GUM

Nicorette [®] 2, 4 mg	Initial: MAX:	1 piece every 1–2 hrs. 24 pieces/24 hrs.	Treatment Duration: 8–12 wks.
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LOZENGE

Commit [®] 2, 4 mg		1 lozenge/1–2 hrs. (wks 1–6) 1 lozenge/2–4 hrs. (wks 7–9) 1 lozenge/4–8 hrs. (wks 10–12)	Treatment Duration: 12 wks.
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NASAL SPRAY

Nicotrol [®] NS 10 mg/ml	Initial: MAX:	1–2 doses/hr. 5 doses/hr. or 40 doses/day	Treatment Duration: 3–6 mos.
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INHALER

Nicotrol [®] Inhaler 10 mg/cartridge	Initial: MAX:	6–16 cartridges/day 16 cartridges/day	Treatment Duration: 3–6 mos.
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NON-NICOTINE MEDICATION

BUPROPION HCL SR

Zyban [®] 150 mg tablets	Initial: MAX:	150 mg/day (days 1–3) 300 mg/day (day 4+) 300 mg/day	Treatment Duration: 7–12 wks.
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VARENICLINE

Chantix [®] 0.5, 1.0 mg	Initial: MAX:	0.5 mg/day (days 1–3) 0.5 mg/2x/day (days 4-7) 1.0 mg/2x/day (day 8+) 2 mg/day	Treatment Duration: up to 7–12 wks.
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Inclusion of this adult dosage chart is strictly for the convenience of the prescribing provider. Please consult the Physicians' Desk Reference for complete product information and contraindications. This chart does not indicate or authorize insurance benefit coverage for any of these medications. For insurance benefit information, the patient will need to contact his/her insurer directly. The cost or provision of these medications is not included as any part of the Try-To-STOP TOBACCO Resource Center of New Hampshire or QuitWorks-NH program.