PACT
PARTNERSHIP TO ASSIST WITH CESSATION OF TOBACCO

PHARMACY ASSOCIATION OF SASKATCHEWAN

Follow-Up Post Quit
Day 3, 7, 14

PHARMACIST'S INITIALS: ___

Name:_____ Date: _____

Telephone:_____ Cessation Aid: _____

SECTION 1: SMOKING STATUS

It's been_____days since quit date. Have you had any cigarettes/cigar/chew since we last spoke? ☐ Yes ☐ No

If no, congratulate and skip to Section 2.

If yes, when you picked up that cigarette/cigar/chew again, what thoughts were going through your mind? Tell me how you were feeling after you had the lapse?

Have you been able to get yourself on track? Tell me how you were able to do this.

If you haven't been able to get yourself on track, let's talk about how we can get you there.
Offer encouragement and discuss interest in and strategies to continue with the cessation effort.

NOTES: _____

SECTION 2: NICOTINE REPLACEMENT THERAPY

How confident are you that the cessation aid is

working/helping? Are you experiencing any side effects

related to your cessation aid?

Do you have any specific concerns related to the use of your cessation aid?

NOTES: _____