

Cessation Counseling Contact and Referral Form

Name: _____ Phone No: _____

ID# _____ Due Date: ____/____/20____

Address: _____

Smoking Status:

_____ smoker _____ smokes but less _____ quit since pregnancy _____ never smoker

Lives with smokers: no _____ yes _____ (#) _____

Support Person: no _____ yes _____ If yes, who: _____

Reason want to quit: _____

Barriers to quitting: _____

Visit Date							
Counselor's initials							
Ask if smokes							
<i>Smokes same</i>							
<i>Smokes but cut down</i>							
<i>Stop since pregnant</i>							
Advise quit							
<i>Benefits of quitting</i>							
<i>Harm of continuing</i>							
<i>Personalized message</i>							
<i>Acknowledge how difficult</i>							
Assess readiness							
Yes	No						
<i>No but reduce</i>							
Assist quitter							
Quit date							
<i>Support identified</i>							
<i>Support provided</i>							
<i>Educational materials</i>							
Arrange follow-up							
<i>Follow-up appt</i>							
<i>Follow-up phone call</i>							
Referral							
Second Hand Smoke							
<i>Partner smokes</i>							
<i>Smokers in home</i>							

Referred to : _____ Quit Line no _____ yes _____

NOTES: