

Patient Name _____ Date _____

Primary Care Provider _____ DOB: _____

Pharmacist Smoking Cessation Statewide Protocol Visit Summary

___ Today you were prescribed the following smoking cessation medication and instructions:

- Nicotine products (gum, patch, spray, inhaler) _____
- Bupropion SR (eg. Zyban/Wellbutrin) _____
- Varenicline (Chantix) _____
- Bupropion + Nicotine Patch _____

___ Your follow up plan is as follows: _____

If you have questions, my name is _____

Please review this information with your primary care provider.

- or -

___ I am not able to prescribe smoking cessation therapy to you today, because:

- You have a health condition than requires further evaluation from a primary care provider.

- You take medication(s) or supplements that may interfere with a therapy.

- Your blood pressure reading is higher than 140/90. (_____ / _____)

Each of the above requires additional evaluation by another healthcare provider.

Please share this information with your provider.

Pharmacist Name _____

Pharmacy Name _____

Address _____

Phone _____

The above has been:

- Provided to the patient
- Communicated to the primary care provider (Details: _____)

Attention Pharmacy: This is a template document. Please feel free to customize it to your particular company, however you **must retain all elements** set forth by this template.