



Employee Application for Nicotine Replacement Therapy

This form is to be completed by North Metropolitan Health Service (NMHS) employees wishing to quit smoking and access twelve weeks free Nicotine Replacement Therapy (NRT).

Employee Details

Name:		Phone No:	
Email Address:		Department:	

Smoking Assessment

Please select one box for each question

How soon after waking do you have your first cigarette?	<input type="checkbox"/> Within 5min <input type="checkbox"/> 5-30 min <input type="checkbox"/> 31-60 min <input type="checkbox"/> 60+ min	<input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 0
How many cigarettes do you smoke each day?"	<input type="checkbox"/> 10 or less <input type="checkbox"/> 11 – 20 <input type="checkbox"/> 21 – 30 <input type="checkbox"/> 31 or more	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
TOTAL SCORE		=
DEPENDENCE SCORE LOW = 0–2 MODERATE = 3-4 HIGH = 5-6		

Apart from cigarettes, do you use any other forms of nicotine?	<input type="checkbox"/> No <input type="checkbox"/> e-cigarettes <input type="checkbox"/> Vape <input type="checkbox"/> Cigars <input type="checkbox"/> Other
Have you attempted to quit smoking in the past?	<input type="checkbox"/> yes <input type="checkbox"/> no
What is your motivation to quit smoking?	<input type="checkbox"/> Health benefits <input type="checkbox"/> Financial <input type="checkbox"/> Family/ Relationship reason <input type="checkbox"/> Other
Have you set a quit date?	<input type="checkbox"/> yes <input type="checkbox"/> no

Clinical Assessment

Please select one box for each question

Are you under the age of 18yrs?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you had a myocardial infarction?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Are you affected by unstable angina?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Are you affected by severe arrhythmias?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you suffered a recent CVA/stroke?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Are you affected by severe psoriasis/dermatitis?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Are you pregnant or intending to become pregnant?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Are you lactating?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you suffer from a health condition that requires medication?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you have any allergies to medications?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

If you have answered 'yes' to any of the above, please visit the Graylands pharmacy or contact the pharmacist (below) or to discuss if NRT is appropriate for you. It may be recommended that you have an assessment from a doctor before commencing NRT.

If you have answered 'no' to all of the above, please bring or fax/email your completed form to Graylands Hospital Pharmacy (Monday to Friday, 8.30am to 4.30pm - closed public holidays).

To be completed by Applicant

- I have read and understand all of the information in this application.
- I will read the provided written information (e.g. Consumer Medicines Information) on receipt of the NRT.
- I am aware of the benefits of taking NRT to assist me to quit smoking and wish to participate in the free NRT offer.
- I understand I am required to return to the pharmacy for further NRT supply.
- I am aware that I can contact Quitline for further assistance and information on 13 78 48, www.quitnow.info.au or www.quitwa.com.

I have read and understood all the information in this application and the information I have supplied is true and correct.

Name: _____

Signature: _____ Date: _____

To be completed by Pharmacy

	Appointment 1	Appointment 2	Appointment 3
Strength of NRT patches dispensed			
Number of weeks of NRT patches provided			
Type and qty of fast acting NRT dispensed			
Pharmacists name			
Signature			
Date			

Pharmacist: Please file this form in Pharmacy after the first dispensing for auditing purposes.

Graylands Hospital Pharmacy

Telephone (08) 9347 6679 Fax (08) 9384 4586

graylands.dispensary@health.wa.gov.au



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