SAMPLE BRIEF INTERVENTION/ASSESSMENT PROTOCOL

ASK – Systematically identify all tobacco uses at every visit

SMOKING STATUS:  [check one]

- NEVER SMOKED  ➔  ➔  ➔  Encourage continued abstinence
- RECOVERING SMOKER  ➔  ➔  ➔  Any further help needed at this time?
- SMOKER
- OTHER TOBACCO USE (snuff, chew, etc…)

Average number of cigarettes smoked per day? _________
How soon after waking do you smoke your 1st cigarette? ___________

ADVISE – Strongly urge all tobacco users to quit

- Provide a clear, strong personalized message to quit and stay quit

ASSESS – Determine willingness and readiness to make a quit attempt

STAGE OF CHANGE

- Pre-contemplation (Not considering quitting)
- Contemplation (Thinking about quitting)
- Preparation (Ready to quit in next 30 days)
- Action (Off tobacco 1 day to 6 months)
- Maintenance (Off cigarettes 6 mos or more)

If in preparation, ask: What steps have you taken to prepare for your quit attempt? ______________________________

MOTIVATION & CONFIDENCE IN QUITTING

- How important is it for you to quit? Not at all 1…3…5…7…10 Urgent
- How interested are you in quitting? Not at all 1…3…5…7…10 Urgent
- How confident are you that you could succeed at quitting? Not at all 1…3…5…7…10 Very
- If you were to quit, what would be some reasons? ______________________________________________________

ASSIST – Aid the client in quitting

- Evaluate past quitting experience:
  Number of previous quit attempts? ___________
  Specify experience with pharmacotherapy (gum, patches, inhaler, Zyban/Wellbutrin): ________________________

- Discuss quitting strategies & treatment options:
  • NRT
  • Tapering
  • Cold Turkey
  • Self-help materials
  • NicA

  Check client preferences:
  Counseling: • Group____  • Individual____  • Pharm/NRT____
  Give materials; encourage support & use of telephone counseling @ Quitline 1-800 TRYTOSTOP or www.trytostop.org
- Client is medically approved to use NRT

ARRANGE – Schedule follow-up contact

- Offered referral to Tobacco Treatment Specialist: Client would like to be contacted: _____
  Client does not want to be contacted: _____

CLINICAL NOTES:

Name: _________________________  Chart #: ___________________  Date: _______________

Notes:

Provider’s Initials: ________