North Yorkshire County Council

Living Well Smokefree

Varenicline screening questionnaire for advisors

White Rose House, Thurston Road, Northallerton DL6 2NA
E: **stop.smoking@northyorks.gov.uk** T: **01609 797272**

Date	

Client's name				Venue	
Client's tel no.		DOB		NHS No.	
GP's name				GP's Tel. No.	
GP's address					
Advisor's name				Advisor's Tel. No.	

Client's information			**Comments**
1* Is the client registered with a GP?	Yes ☐	No ☐	
2* Does the client offer valid consent?	Yes ☐	No ☐	
3* Does the client consent to share information with GP?	Yes ☐	No ☐	
4* Is client sufficiently motivated to quit or use Varenicline?	Yes ☐	No ☐	
5* Has client had an unsuccessful attempt to quit using Varenicline on the programme in the last six months?	Yes ☐	No ☐	
6* Is client under the 18 years of age?	Yes ☐	No ☐	
7* Is client pregnant or breastfeeding?	Yes ☐	No ☐	
8* Is client allergic to Varenicline or any of its excipients? Document any other known drug allergies.	Yes ☐	No ☐	
9* Is the client using any other smoking cessation therapy?	Yes ☐	No ☐	
10* Has the client's GP recommended that they do not use Varenicline?	Yes ☐	No ☐	
11* Does the client pay prescription charges? Has exemption been confirmed?	Yes ☐ Yes ☐	No ☐ No ☐	
Medical and psychiatric history			
12* Has the client been told that they suffer from poor kidney function (history of renal impairment or end stage renal disease)?	Yes ☐	No ☐	
13* Does the client have history of psychiatric illness or currently suffer from Schizophrenia, bipolar, depression, anxiety, eating disorder, history of deliberate self-harm, previous suicide attempts etc.?	Yes ☐	No ☐	
14* Has the client had an acute admission to a hospital for their mental health due to relapse of mental illness and required input by the mental health team/GP/ psychiatrist condition in the past 6 months?	Yes ☐	No ☐	
15* During the last month, has the client often been bothered by feeling down, depressed or hopeless?	Yes ☐	No ☐	
16* During the last month, has the client often been bothered by having little interest or pleasure in doing things?	Yes ☐	No ☐	
17* Does client suffer from epilepsy or fits?	Yes ☐	No ☐	
18* Does the client have a history of or presently suffer from unstable cardiovascular disease or are they at risk of myocardial infarction/heart attack/angina	Yes ☐	No ☐	
Social History			
19* How many units of alcohol does the client drink a week? No (no more than 14 units per week for men and women)	Yes ☐	No ☐	
Varenicline treatment schedule, side effects and relevant cautions			
20* Has the treatment schedule been discussed with the client?	Yes ☐	No ☐	
21* Have the side effects of Varenicline been explained to the client?	Yes ☐	No ☐	
22* Has the client been advised about dose tapering if Varenicline is not tolerated due to nausea and vomiting?	Yes ☐	No ☐	
23* Has the client been advised about medication administration?	Yes ☐	No ☐	
24* Has the client been advised to immediately stop treatment and see GP/doctor if they become unwell?	Yes ☐	No ☐	
25* Has the client been informed of the possibility of withdrawal symptoms?	Yes ☐	No ☐	
26* Has the client been cautioned about driving and/or operating machinery or undertaking other cognitive tasks whilst using Varenicline?	Yes ☐	No ☐	
27* Have you explained to the mode of action of Varenicline?	Yes ☐	No ☐	
28 Has the client been asked to read the Patient Information Leaflet supplied with the Varenicline?	Yes ☐	No ☐	
General stop smoking advice			
29* Has general stop smoking advice been discussed with the client?	Yes ☐	No ☐	
30 Has the client been informed of the weekly follow up appointments and behavioural support	Yes ☐	No ☐	
Medication history			
31 Is client on any other medication? Please list all regular medications taken (both prescribed and not prescribed).	Yes ☐	No ☐	

32 If client is on any of the medication listed below, please notify the GP to adjust the drug dose and monitor the drug levels through appropriate blood tests if indicated as deemed appropriate by the GP

☐ Theophylline	☐ Fluphenazine	☐ Propranolol	☐ Clozapine
☐ Warfarin	☐ Fluvoxamine	☐ Tricyclic antidepressants	☐ Insulin
☐ Benzodiazepines	☐ Haloperidol	☐ Zolpidem	☐ Any other relevant medication
☐ Chlorpromazine	☐ Methadone	☐ Lithium	
☐ Duloxetine	☐ Olanzapine	☐ Memantine	

Additional notes made by the Stop smoking advisor:

Client's consent: "I hereby consent to share the information relating to my use of this service to be passed on to my GP and to Living Well Smoke Free for the purposes of continuing proposed treatment as documented above, evaluation and audit. I declare that the information above is correct and complete to the best of my knowledge."

Advisor's signature: .... Client's signature: ....

~~White copy: Client~~ - ~~Yellow copy: Advisor~~ - ~~Pink copy: GP~~