

Form Title **Tobacco Reduction Care Pathway**

Form Number **21127**

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Tobacco Reduction Care Pathway

Last Name	
First Name	
PHN#	MRN#
Birthdate (dd-Mon-yyyy)	Physician

Tobacco and Smoke Free Environment - Admission (ED or Inpatient)

Inform patient/family of AHS Tobacco & Smoke-Free Environments Policy – Policy Postcard and/or signage

Tobacco/Tobacco Like Product Use Status - Admission (ED or Inpatient)

'As a standard of care, we ask everyone about their tobacco use. Have you used tobacco or tobacco-like products in the last 30 days?'

Refused - **If patient unable to answer wait to determine status at bedside**

No - **Stop**

Yes - **Go to Withdrawal Comfort ▼**

Completed by (print name)

Date (yyyy-Mon-dd)

Withdrawal Comfort - Admission (ED or Inpatient)

'Are you interested in pharmacotherapy to help you not use tobacco/tobacco-like products during your stay?'

No (remind patient they cannot use tobacco or tobacco like products on site but can ask for withdrawal comfort as needed)

Yes - Use Nicotine Replacement Therapy Inpatient form or formulary.

Go to Therapeutic Intervention ▼

Completed by (print name)

Date (yyyy-Mon-dd)

Therapeutic Intervention - AAR (ED Triage or Inpatient Bedside)

If completing 5A Brief Tobacco Intervention use Form #18251

If completing Intensive Tobacco Intervention use Form #18252

Ask

Tobacco

Which of the following describes your use of tobacco products (cigarettes, cigars, smokeless tobacco, etc.)?

- Never Use
- Previous Use (quit over a year ago)
- Recent Quit (in last year)
- Current Use (in last 30 days)

Tobacco (Describe the type, amount and years of use)

Tobacco-Like

Which of the following describes your use of tobacco-like products (electronic cigarettes, cannabis, etc.)?

- Never Use
- Previous Use (quit over a year ago)
- Recent Quit (in last year)
- Current Use (in last 30 days)

Tobacco-Like (Describe the type, amount and years of use)

Advise

Tobacco

Patient advised 'Not using/stopping tobacco use is one of the best things you can do for your health/treatment outcomes and we can help you'
(personalize to health issue as able)

Tobacco-Like

Patient advised 'Any substance that is smoked or vaped may have harms and therefore is not recommended'.
(personalize to health issue as able)

Tobacco Reduction Care Pathway

Last Name	
First Name	
PHN#	MRN#
Birthdate (<i>dd-Mon-yyyy</i>)	Physician

Refer

'There are trained health professionals that can support your efforts to reduce or stop tobacco use here and when you return home. May I refer you to one or more of them?'

- patient declined
 patient agreed - **Go to Referral ▼**

Referral (*ED Triage or Inpatient Bedside*)

Patient referred to (*choose all that apply*)

- Onsite Support _____
 AlbertaQuits – online, helpline or group support - complete AlbertaQuits Fax Referral Form 09973
 Primary Care Physician/Clinic _____
 Other _____

Completed by (*Last name, First name*)

Date (*yyyy-Mon-dd*)