QUITWORKS[SM]

UMassMemorial

Name: ______________________

Address: ______________________

____

Birth date: ______________________ Sex: __________

Unit Number: ______________________

PRINT CLEARLY IN INK OR IMPRINT WITH PATIENT'S CARD

Tobacco Treatment Enrollment

A Collaboration of the Mass. Department of Public Health & Mass. Health Plans

Tobacco Treatment Checklist

ADVISE smoker to stop: ❑ Stop-smoking advice given: "I strongly advise you to quit smoking and I can help you."

ASSESS readiness to quit: ❑ Ready to quit ❑ Thinking about quitting ❑ Not ready to quit

ASSIST to quit: ❑ Brief counseling Reasons to quit • Barriers to quitting • Lessons from past quit attempts
Set quit date, if ready • Enlist social support

❑ Medication if appropriate
Nicotine Replacement: ❑ patch ❑ gum ❑ lozenge ❑ inhaler ❑ nasal spray Other: ❑ Bupropion (Zyban®/Wellbutrin SR®)

ARRANGE follow-up: ❑ Refer to: Try-To-STOP TOBACCO Resource Center by faxing the lower part of this form toll-free to **1-866-560-9113.**

TRY-TO-STOP TOBACCO RESOURCE CENTER OF MASSACHUSETTS
Massachusetts Resident Enrollment Form

Fax this part of form to 1-866-560-9113.

REFERRAL SOURCE/FOLLOW-UP CONTACT

referred by name: Project Manager, Office of Quality and Patient Safety facility: UMMMC address: 16 Shaffner Street Worcester, MA 01605	phone (area code + number) **(508) 793-6457** fax (area code + number) **(508) 334-1124**

follow-up report contact	phone (area code + number)	fax (area code + number)
Project Manager, Office of Quality and Patient Safety	**(508) 793-6457**	**(508) 334-1124**

PATIENT

first name	last name	date of birth (month/day/year)

phone (area code + number)	May we leave a message?	language preference (check):
( )	❑ yes ❑ no	❑ English ❑ Spanish ❑ other (specify) __________

email address

client address	city	state	zip

PRIMARY INSURANCE – check one

MASS HEALTH/MEDICAID Check one: ❑ PCC Plan ❑ BMC Health Net ❑ Fallon ❑ Neighborhood Health Plan ❑ Network Health ❑ Fee for Service

MEDICARE SUPLEMENTAL PLAN ❑ Blue Cross Blue Shield MA ❑ Harvard Pilgrim ❑ Tufts Health Plan ❑ Fallon

COMMERCIAL INSURANCE Check one: ❑ Blue Cross Blue Shield MA ❑ Harvard Pilgrim ❑ Tufts Health Plan ❑ Neighborhood Health Plan
❑ Fallon ❑ Other __________

UNINSURED ❑

THE RESOURCE CENTER USUALLY CALLS THE CLIENT WITHIN 3 BUSINESS DAYS OF RECEIVING A REFERRAL. WHEN SHOULD WE CALL?

check all that apply: ❑ morning ❑ afternoon ❑ evening ❑ no preference

I, ______________________, hereby authorize Try-To-STOP TOBACCO Resource Center of Massachusetts, (the "Resource Center"), and its representatives to disclose information about me to:

1) the American Cancer Society Quitline to the extent necessary to allow me to participate in its tobacco cessation counseling program; and
2) my primary care provider or other provider ("Provider") I designate to the Resource Center to the extent the Resource Center deems necessary to give my Provider an update of my progress in attempting to stop smoking.

I authorize my Provider to release the information on this enrollment form to the Resource Center for purposes of my participation in the QuitWorks program.
I also authorize the Resource Center and its representatives to contact me upon receiving this referral from my Provider.

______________________ ______________
SIGNATURE OF QUITWORKS CLIENT OR CLIENT'S REPRESENTATIVE DATE

______________________ ______________
PRINTED NAME OF QUITWORKS CLIENT REPRESENTATIVE RELATIONSHIP TO CLIENT

* AVAILABLE ON UMMMC FORMULARY

QUITWORKS℠

Quick Guide To Pharmacotherapy In Tobacco Treatment

NICOTINE REPLACEMENT OPTIONS

PATCHES

Nicotrol® 15 mg	Initial:	1 patch/16 hrs.	Treatment Duration: 8 wks.
	MAX:	Same as above	
* Nicoderm® CQ 7 mg, 14 mg, 21 mg	Initial:	1 patch/24 hrs.	Treatment Duration: 8 wks.
	MAX:	Same as above	

*GUM

Nicorette® 2 mg, 4 mg	Initial:	1 piece every 1–2 hrs.	Treatment Duration: 8–12 wks.
	MAX:	24 pieces/24 hrs.	

LOZENGE

Commit® 2 mg 4 mg		1 lozenge/1–2 hrs. (wks 1–6)	Treatment Duration: 12 wks.
		1 lozenge/2–4 hrs. (wks 7–9)	
		1 lozenge/4–8 hrs. (wks 10–12)	

NASAL SPRAY

Nicotrol® NS 10 mg/ml	Initial:	1–2 doses/hr.	Treatment Duration: 3–6 mos.
	MAX:	5 doses/hr. or 40 doses/day	

INHALER

Nicotrol® Inhaler 10 mg/cartridge	Initial:	6–16 cartridges/day	Treatment Duration: 3–6 mos.
	MAX:	16 cartridges/day	

NON-NICOTINE MEDICATION

BUPROPION HCL SR

* Wellbutrin SR 150 mg tablets	Initial:	150 mg/day (days 1–3)	Treatment Duration: 7–12 wks.
		300 mg/day (day 4+)	
	MAX:	300 mg/day	

VARENICLINE

Chantix®	Initial:	0.5 mg/day (days 1–3)	Treatment Duration: Up to 12 weeks
		0.5 mg/2x/day (days 4–7)	
		1.0 mg/2x/day (day 8+)	
	MAX:	2 mg/day	

Inclusion of this adult dosage chart is strictly for the convenience of the prescribing provider. Please consult the Physicians' Desk Reference for complete product information and contraindications. This chart does not indicate or authorize insurance benefit coverage for any of these medications. For insurance benefit information, the patient will need to contact his/her insurer directly. The cost or provision of these medications is not included as any part of the Try-To-STOP TOBACCO Resource Center of Massachusetts or QuitWorks program.

* AVAILABLE ON UMMMC HOSPITAL FORMULARY

Make smoking history.