Practitioner Communication Letter

Dear: ____

Re (Patient Name and Address): ____________ ______________________________

____

HSN:______________________________ **DOB:** ______________________________

I have spoken to our patient about their <u>smoking/tobacco status</u>. They have chosen to:

☐ Not quit at this time
☐ Enroll in the Partnership to Assist with Cessation of Tobacco (PACT) program and receive cessation counseling services for up to a year with this pharmacy
☐ Commit to a quit date of: ____________ ______________________________

Our patient has chosen:

☐ No cessation therapy/quit cold turkey
☐ Reduce to quit
☐ OTC nicotine replacement therapy with: _______ ______________________________
☐ Combination therapy with: ____________ ______________________________
☐ I have prescribed prescription cessation therapy as per Minor Ailment Prescriptive Authority

Date:______________________________ **Signature:** ______________________________

If you have any questions or concerns, I would be pleased to speak with you further about any of these issues.

Pharmacist Name: ____

Pharmacy Contact Information: