Consent to be shown on medical records ☐ **Yes** ☐ **No**

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Consultation Record Form

Care Co-ordinator name: _____ **Location/Setting:** _____

Care Co-ordinator Tel No: _____ **1st Assessment Date:** _____

Full Name:			**NHS ID No:**		
Address:				**Post Code:**	
Daytime Tel No:		**Mobile No:**			
Age:		**Date of Birth:**			

For Young People: I understand that this service works within the 'Fraser Guidelines'

Consent for disclosure:	☐ Yes	☐ No	**Client's GP:**
Consent to contact Parent/Guardian	☐ Yes	☐ No	

Gender:	Male/Female
Pregnant: Yes/No	Breast Feeding Yes/No
Entitled to Free Prescriptions	Yes/No

Client Occupation Code

- ☐ Full time student
- ☐ Never worked or unemployed for over 1 year
- ☐ Retired
- ☐ Sick/disabled and unable to return to work
- ☐ Home carer (unpaid) looking after children, family, home
- ☐ Managerial and professional occupation
- ☐ Intermediate occupations
- ☐ Routine & manual occupation
- ☐ Unable to code

Practice:

Ethnic Background – please tick one box

White	**Black or Black British**
☐ British	☐ Caribbean
☐ Irish	☐ African
☐ Other White background	☐ Other Black Background
Mixed	**Asian or Asian British**
☐ White & Black Caribbean	☐ Indian
☐ White & Black African	☐ Pakistani
☐ White & Asian	☐ Bangladeshi
☐ Other Mixed Background	☐ Other Asian Background
Other Ethnic Group	
☐ Chinese	☐ Other Ethnic Group

Type of Intervention
(Please tick ONE type)

- ☐ Group (closed)
- ☐ Group (rolling)
- ☐ Drop in Clinic
- ☐ One to One Support
- ☐ Couple/Family
- ☐ Telephone Support
- ☐ Other
- ☐ Children's Centre
- ☐ Work Places

Where did you find out about our service?
(Please tick relevant box)

☐ GP	☐ Children's Centre	
☐ Self Referral	☐ Telephone Call	
☐ Hospital Consultant	☐ New Attempt	
☐ Dentist	☐ Pharmacist	
☐ Midwife	☐ Friend	
☐ Other Health Professional	☐ Smoke Free Bus	
☐ Relative	☐ Helpline	

☐ Other – please specify

Pharmacotherapy

Type of Pharmacological Support Used: (please tick all relevant boxes. Use 1 or 2 to indicate consecutive use of more than one medication – e.g. Champix followed by NRT product)

None	☐
NRT – Lozenge	☐
NRT - Microtab	☐
NRT – Inhalator	☐
NRT - Spray	☐
NRT – Gum	☐
NRT - Patch	☐
NRT - Strips	☐
Zyban	☐
Champix	☐
Is the client using Electric Cigarettes	☐

1st Assessment CO Reading	
Quit Date Set **QUIT DATE MUST BE SET**	
No Quit Date Set	

Treatment Outcome

4 week CO ppm	
Date of last tobacco use	
Date of 4 Week Follow Up	

4 Week Outcome (please tick)

Quit Co Verified	☐
Quit Self Report	☐
Not Quit	☐
Lost To Follow Up	☐

Clients Signature: _____ **(indicates consent to Systmone share/ treatment/ follow-up/pass on of outcome data to tPCT)**

Advisor Signature: _____ **Date:** _____

Medical History :

Current Medication :

Smoking History

Average number smoked per day

Time to 1st smoke after waking

Smokefree Homes Information

No of children in the home

No of other smokers in home

Notes continued: Was the home sf before quit attempt after quit attempt

Date	Note	Treatment given/ Action taken	CO reading