LSU Health Care Services Division

Out-patient Tobacco Cessation Referral Form

MRN:
Patient Name:
DOB:
Gender:
Date:
Inmate: Yes No

Facility: ______________________________

Clinic: ______________________________

Home Phone: ____________________________ Cell Phone: ____________________________

Alternate phone: (__Work, __Family Member, __Other): ____________________________________

Mailing Address: ____

Was patient advised to quit tobacco use?	Yes ☐	No ☐
Is patient ready to quit within the next 30 days?	Yes ☐	No ☐
Was patient given self-help material?	Yes ☐	No ☐

Was Medication Consult provided by physician?	Yes ☐	No ☐
Does patient want **Medication Only**?	Yes ☐	No ☐

Consulting Physician:
Printed name (or stamp): ____

Signature: ______________________________ Date: ____________________

Medication Prescribed (please attach prescription to referral form)

Wellbutrin SR ☐ 1 Q Day X3 Days, then 1 PO BID
150 mg, #120, no refills

Wellbutrin XL ☐ 1 Q Day X3 Days, then 1 PO BID
300 mg, #120, no refills

Chantix ☐ Day 1-3: 0.5 mg once daily; Day 4-7: 0.5 mg twice daily; Day 8-end of 12 week treatment: 1mg twice daily

NRT Patch ☐ For > 10 Cigarettes apply 1 patch (21mg)
Transdermal route once daily for 2 weeks

☐ For < 10 Cigarettes apply 1 patch (14mg)
Transdermal route once daily for 2 weeks

Other: ____

If no medication prescribed, please check reason:

☐ Pregnant ☐ Seizure Disorder ☐ Eating Disorder ☐ Refused ☐ Other ______________________________

HCSD TCI 1003 (Rev9 2/07)