

Smoking Cessation Assessment Practice/Site Survey

Initial

Follow-up

Date:

Name:

Practice/Site Name:

Title:

Please fill complete this form: Be as accurate as you can be. (Check one)

- This applies to me only
 This applies to my practice overall

Statements	Always	Most of the time	Some of the time	Rarely	Never	Not applicable
1. We/I ask about smoking and exposure to tobacco smoke pollution at each client contact.						
2. We/I advise all smokers to quit smoking at each client contact.						
3. We/I assess willingness to stop smoking and document smoking status in patient medical record or problem list.						
4. We/I assist with brief quit smoking cessation counseling to smokers and recent quitters at each visit.						
5. We/I give information to smokers about community quit smoking counseling programs						
6. We/I give information to patients about the free quit line						
7. We/I fax referrals to the quit line using the fast fax referral form						
8. We/I distribute "Quit Smoking" self-help materials.						
9. We/I recommend/prescribe pharmacotherapy for smokers, if clinically appropriate.						
10. We/I document cessation interventions in the client record to track and evaluate progress.						
10. We/I identify smokers with chart stickers or other prompts.						
13. We/I monitor staff compliance to ensure they provide smoking interventions/programming.						
14. We/I currently bill for smoking cessation counseling						