Mercy

PHI Communication Resource Tool

Please print below information

I, _____, hereby authorize release of my Protected Health Information for discussion of my care or treatment to the person(s) specified below (45CFR, 164.502(F) & 164.502(G):

Authorized family member or person to receive verbal information for the above named patient's care:

Name of Central Contact (Other than patient)	Relationship to Patient	Phone

Others authorized to receive my verbal information (please list names and relationship):

Print Name	Relationship to Patient	Phone

Print Name	Relationship to Patient	Phone

Email

♦ Note: This form does not give the above referenced persons permission to make health care decisions for the patient or entitle them to paper or electronic copies of the patient's medical record. We will not release via the telephone or any other means of communication any information to any friends or family members not listed above unless the patient has an opportunity to object and does not (documented) or if it is reasonable to infer that the patient does not object such as when a patient brings a spouse into the room when treatment is being discussed. Exception: if the release is needed in emergency situations.

♦ Do you wish to be a confidential or non-published patient for directory status? ☐ Yes ☐ No
(Example: If you are in our facility seeking treatment and a visitor calls or stops in to see you do you want to remain private and we will not acknowledge you as a patient? Confidential patients will not receive mail or flowers.)

♦ Leave message on answering machine? ☐ Yes ☐ No
(Example: We may leave message reminders, scheduling changes or notices that lab results are in on your answering machine. Would this process be acceptable, yes or no?)

♦ Leave message for patient to return call? ☐ Yes ☐ No
(Example: We may leave a message regarding appointment reminders, scheduling changes or notices that lab results are in with an individual who answers the phone. Would this process be acceptable, yes or no?)

Patient or Legal Personal Representative:_____ Date: _____
(SIGNATURE)

Patient or Legal Personal Representative:_____ Relationship to Patient: _____
(PRINTED NAME)

Note: Except to the extent that action has already been taken in reliance on this PHI Communication Resource Tool, at any time I can revoke this PHI Communication Resource Tool by submitting a notice in writing to the Privacy Site Coordinator or Privacy Site Designee.

Patient Name:_____

MRN #: _____

Date of Birth: _____

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A Plan to Get Ready to Quit Tobacco

Congratulations! The first step to quitting tobacco is a heartfelt desire to be tobacco free! See, you are already on your way to a healthier tobacco free lifestyle! You will work with a health care professional (CTTS/ Wellness coach) who will assist you in developing a successful "quit plan" individualized for YOU! If your quit date is not already in mind, there are several "preparation steps" which help prepare you to have a successful quit. Remember it takes 21-30 days to change a habit.

Rate these steps as 1 = NOT important to me at this time to 5 = MOST important to me as a starting point.

____ I am buying my cigarettes one pack at a time

Tip: *No more cartons make it less convenient, cost more and helps you to be more aware / mindful*
Tip: *Buy a different brand that you don't like*

____ I am informing my friend or family of my decision to stop using tobacco

Tip: *It helps those around you understand and support you in your plan*
Tip: *When others know your plan, you will find you're more motivated toward your goal*

____ I am getting a "reward jar" ready, so I can place the money that I save in it, for something special for me

____ I am not smoking in my house or garage

Tip: *Remove ashtrays from home or garage*
Tip: *Put cigarettes / tobacco in an inconvenient location (trunk of car, high on a shelf, out in the shed)*
Tip: *Wash Bedspreads, curtains, refresh upholstery with "Febreze" or similar product*

____ I am standing not sitting when I smoke outside

____ I am not smoking in my car

Tip: *Clean your car, remove ashtrays*
Tip: *Spray with citrus or peppermint scented air fresheners*
Tip: *Build your "survival kit" and put one or two in the car*

____ I am replacing tobacco use today with a different activity

Tip: *Don't try and replace the first cigarette of the day yet, generally that is most challenging to give up*

____ I am changing the way I hold my cigarette in my hands

Tip: *Holding your cigarette in an unfamiliar way makes smoking unpleasant and changes habit formation*

____ I am replacing two or more cigarettes a day with a different activity

____ I am postponing each cigarette or tobacco use by 5-10 minutes

Tip: *Set a timer and wait for it to go off before you smoke or use tobacco*

____ I am postponing each cigarette / tobacco use by 15 minutes

Mercy

Tobacco Questionnaire

In order to help you become tobacco-free we need to understand your habits and feelings about using tobacco. Please answer the following questions regarding your tobacco use, your motivation for quitting and what concerns you have about continued use.

Reasons for Using Tobacco

Please use the following scale to answer the next set of questions 1 = not at all 5 = somewhat 10 = definitely

	For cigarettes, cigars, and pipe users only:	1	2	3	4	5	6	7	8	9	10
1	I smoke to wake myself up. (Stimulation)										
2	I enjoy handling my cigarettes and lighters. (Handling)										
3	Smoking helps me relax. (Relaxation)										
4	Smoking calms me when I'm upset. (Ease tension)										
5	I crave a cigarette after not smoking for a while. (Craving)										
6	I light a cigarette without realizing I have one still burning. (Habit)										
7	**How important is it for you to quit?**										
8	**How confident are you to stop tobacco use?**										
	For smokeless tobacco users only:	1	2	3	4	5	6	7	8	9	10
1	I chew to perk myself up. (Stimulation)										
2	Chewing helps me relax. (Relaxation)										
3	Chewing calms me when I'm upset. (Ease Tension)										
4	I chew to satisfy the sensation in my mouth (Gratification)										
5	I chew as an alternative to smoking (Replacement)										
6	I chew because the effects last longer (Craving)										
7	**How important is it for you to quit?**										
8	**How confident are you to stop tobacco use?**										

Tobacco Use History

1. What do you enjoy about tobacco use? _____

2. **How soon after you wake up do you use tobacco?

	Within 5 minutes (3)		6-30 minutes (2)		31-60 minutes (1)		After 60 minutes (0)

1. **Do you find it difficult not to use tobacco in places where you shouldn't, such as in church, on the bus, in the school or at the library? **Yes** (1)**/ No** (0)

2. **Which tobacco time would you most hate to give up?

	The first one in the morning (1)		Any other one _____ (0)

5. **How many cigarettes do you smoke each day? (If Tobacco chewer or pipe see question 6 or 7)

	10 or less per day (0)		11-20 per day (1)		21-30 per day (2)		31 or more per day (3)

6. **How many Cigars or Pipe usage per day?

	1 or fewer (0)		2-3 per day (1)		1-5 per day (2)		6 or more per day (3)

7. **How many bags or cans of tobacco, plugs or Snus a day?

	1/4 per day (0)		1/2 per day (1)		3/4 -1 per day (2)		2 or more per day (3)

8. ** Do you use tobacco more frequently during the first hours after waking up than during the rest of the day? **Yes** (1)**/ No** (0)

9. **Do you use tobacco if you are so sick that you are in bed most of the day? **Yes** (1)**/ No** (0)

10. Type of smokeless tobacco *(circle)*:

Dip Loose leaf Plug Tobacco gum Dissolvable tobacco Creamy snuff Nasal snuff Snus

11. What other tobacco containing products do you use? *Please check all that apply.*

A	Bidis (Hand Rolled Cigarettes)		D	Tobacco Strips	
B	Kreteks (Clove Cigarettes)		E	Water Pipes	
C	Tobacco "Orbs"		F	Hookahs	

13. How many years have you used tobacco products?_____

14. Who around you uses tobacco products? _____

Tobacco Cessation History

1. Whose ideas is it to quit? *(circle)* Self Spouse Children Job Insurance Reduction

2. Have you ever tried to quit? Y / N How many times?_____

3. Were you ever successful? Y / N For how long? _____

4. What would happen if you quit using tobacco products? _____

5. How soon do you want to make this commitment? _____

6. What is the most important reason for you to quit? _____

7. What is the number of times you have relapsed? _____

8. After how long of smoking, was the very first time you tried to quit? _____

9. Please check which one applies about your quit history.

A	I have never wanted to quit	
B	I have wanted to quit but never tried	
C	I have tried to quit but not successful	
D	I have quit and succeeded, but due to circumstances I started again	

10. What do you think will help you **not** start again? *Please mark all that apply.*

A	Changing Attitude		D	Determination / Willpower	
B	Support From Others		E	If Spouse / Family / Friend also quit	
C	Desire to be Tobacco Free		F	Mindfulness, or other stress relievers	

11. What fears do you have about your effort to quit? *Please mark all that apply.*

A	Cravings		G	Increased stress	
B	Weight gain		H	Lack of confidence	
C	Inability to quit		I	Withdrawal symptoms	
D	Sense of Loss		J	Feeling controlled by the habit	
E	Nervousness		K	Loss of "best friend"(cigarette)	
F	Mood changes				

12. Are you **currently** using any nicotine replacement products or pharmaceuticals? *Please mark all that apply.*

	Products	Check Box	**Helping** you reduce	Complications
A	Chantix	Y / N	Y / N	
B	Wellbutrin	Y / N	Y / N	
C	Nicotine Gum	Y / N	Y / N	
D	Nicotine patches	Y / N	Y / N	
E	Nicotine inhalers	Y / N	Y / N	
F	Nicotine Lozenges	Y / N	Y / N	
G	Electronic Cigarettes (nicotine based or flavored only)	Y / N	Y / N	

13. Have you **used in the past** any nicotine replacement products s or pharmaceuticals? *Please mark all that apply.*

	Products	Check Box	**Helped** you reduce	Complications
A	Chantix	Y / N	Y / N	
B	Wellbutrin	Y / N	Y / N	
C	Nicotine Gum	Y / N	Y / N	
D	Nicotine patches	Y / N	Y / N	
E	Nicotine inhalers	Y / N	Y / N	
F	Nicotine Lozenges	Y / N	Y / N	
G	Electronic Cigarettes (nicotine based or flavored only)	Y / N	Y / N	

14. What concerns you about your habit? *Please mark all that apply.*

A	Odor		G	Heart disease	
B	Cost		H	Relationships	
C	Cancer		I	Inability to breath	
D	Children		J	What others think	
E	Disability		K	Insurance Increases	
F	Early Aging		L	Other:	

15. What tools **are working** for you or **have worked** in the past? *Please mark all that apply.*

A	Straws		G	Housework	
B	Exercise		H	Mindfulness	
C	Hobbies		I	Deep breathing	
D	Rationing		J	Coaching Support	
E	Relaxation		K	Auricular Therapy	
F	Hard Candy		L	Other:	

16. What are your triggers? *Please mark all that apply.*

A	Food		E	Work	
B	People		F	Social	
C	Environmental		G	Vehicle	
D	Stress (Please circle which ones apply) Home Work Personal Health Financial		H	Alcohol (Please circle which one) Daily occasional with smoking	

Signature _____ Date_____