Patient Name: ____ Date: ___/_____/_____
Patient DOB: ____________________________________

Nicotine Replacement Therapy Documentation & Communication Form

Tobacco / Nicotine Use Assessment: □ High □ Medium □ Low
Based on: □ Self-reported intake □ Time to first intake □ Other

□ Previous quit attempts □Products used previously

Intake Comments:

Is the patient pregnant or breastfeeding? □ Yes □ No
If yes, did education include the risks of smoking/vaping vs. the possible risks of NRT? □ Yes □ No
If yes, did the education include use of intermittent NRT through pregnancy and breastfeeding? □ Yes □ No

Patient signature if they choose to use NRT: __________________________________Date:_____________________

Is the patient < 18 years of age? □ Yes □ No
If yes, what is the name of the consenting parent or legal guardian? ____
Signature of parent or legal guardian ____Date:_____________________

Did the patient identify a primary care provider? □ Yes □ No
If yes, this communication to the primary care provider must be provided within 72 hours after administration of medication.
If no, the patient shall be directed to information describing the benefits of having a primary care provider.

Tobacco Cessation Therapy Initiated:		**Qty**	**Any Specific Notes/Comments for PCP**
Nicotine patch	□ **7 mg**, □ **14 mg,** □ **21 mg**	Nicotine Oral Inhaler	□ **10 mg Cartridge**
Nicotine gum	□ **2 mg,** □ **4 mg**	Nicotine Nasal	□ **0.5mg Spray**
Nicotine lozenge	□ **2 mg,** □ **4 mg**		

□ **Provided product instructions per package insert**
Patch Use Directions: Apply patch to non-hairy, clean, dry skin on upper body between the neck and waist. Remove the previous day's patch before applying new patch. Rotate or switch site where apply patch daily. If you have intense, clear, troubling dreams or you cannot fall asleep only wear patch 16 hours per day with removal at bedtime.
Gum Use Directions: Chew gum slowly until it tingles, then park between gum and cheek until tingling stops. Chew again until tingle returns and re-park. Repeat until tingling is gone and discard gum. Do not eat or drink while using gum.
Lozenge Use Directions: Dissolve in mouth (do NOT bite). Move around in different places in mouth until taste/tingling stops. Do not eat or drink while using lozenge.
Oral Inhaler Directions: Puff gently. Typical use is 5-6 cartridges per day; oral absorption, don't inhale deeply
Nasal Spray Directions: Spray 1-2 doses/hour and up to 8-40 doses per day; do not sniff or inhale; tilt head back and spray

□ **Potential adverse effects, per package insert, reviewed with patient**
Patch: local skin reactions, headache, sleep disturbances
Gum/Lozenge: burning/tingling in mouth, dyspepsia, hypersalivation, hiccups, headache
Oral inhaler: mouth/throat irritation, headache, rhinitis, hiccups, dyspepsia
Nasal spray: nasal/throat irritation, rhinitis, tearing, sneezing, cough, headache

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

Patient Name: ____ Date: ___/_____/_____
Patient DOB: ____________________________________

Follow-up Plan With Patient: □ 1 week □2 weeks □1 month □12 weeks □other
Quit Date Set: _________________
____

☐ **Provided behavioral support OR referral to 1-800-QUIT NOW program OR other behavioral counseling resource:**

Pharmacist Name: Pharmacist NPI #:
Pharmacy Address:

To: [Primary Care Physician]
From: [Pharmacy / Practice Name]
[Pharmacy / Practice Address]

This letter serves to notify you that our shared patient has been dispensed nicotine replacement therapy (NRT) per North Carolina NRT Standing Order, which permits immunizing pharmacists practicing in North Carolina to dispense, deliver, or administer NRT. Please see the attached documentation for your records.

If you have any questions, please call the pharmacy at [pharmacy phone #].

[Pharmacist Name]
[Pharmacist NPI #]