



Patient Stamp, Label or Info (Name, Record Number/DOB, Date)

- If a patient is interested in quitting smoking, fill out this form with them
 - Fax **completed** form to 1-866-560-9113.
 - The Rhode Island Smokers' Helpline will contact the patient, offer free cessation services and send feedback reports to the provider below.
- This program is free for all Rhode Island residents regardless of insurance status.

Formulario de inscripción de Rhode Island

La persona que usa tabaco debe completar la siguiente sección

Nombre _____ Apellido _____ **¿Tiene 18 años de edad o más?** Sí No

Dirección postal _____ Ciudad _____ Estado _____ Código postal _____
()

Número de teléfono _____

- ¿Cuándo prefiere que llamemos? (marque todo lo que corresponda) Mañana Tarde Noche Ninguna preferencia
- Preferencia de idioma: Inglés Español Otro (especificar) _____
- ¿Podemos dejar un mensaje? Sí No
- Seguro principal de la persona que usa tabaco: BCBS of RI United Healthcare Neighborhood Health Plan Tufts Medicare Medicaid (check one): Rite Care Connect Care Rhody Health Otro Ninguno

Autorizo a este proveedor de servicios de salud a dar la información de este formulario de inscripción a QuitWorks-RI para que puedan contactarme y pueda participar en el programa QuitWorks-RI. También autorizo a QuitWorks-RI a dar información sobre mi progreso en el intento de dejar de fumar al proveedor de servicios de salud nombrado en este formulario.

Firma de la persona que usa tabaco Fecha

Los proveedores de servicios de salud completarán esta sección (Health care providers complete this section)

Referring Provider: _____ Phone Number () _____

Facility: _____ Fax Number () _____

Address: _____

Send feedback report to:
 Same as above or _____

Name Phone Number Fax Number

PEDIATRICS ONLY:

Patient's relationship to child: Mother Father Other (specify) _____

Child's name: (to help with your recordkeeping) _____

Copies of this form can be downloaded from WWW.QUITWORKSRI.ORG
Fax this form toll-free to 1-866-560-9113

LONG-ACTING PRODUCTS

PATCHES

21 mg, 14 mg, 7 mg

Dose: 1 patch every 24 hrs.
Start: 21 mg patch if ≥ 10 cig/day
14 mg patch if < 10 cig/day

Duration:
6-14 wks

SHORT-ACTING PRODUCTS

GUM

2mg, 4 mg

Dose: 1 piece every 1-2 hrs.
Max: 24 pieces/day

Duration:
6-14 wks

LOZENGE or MINI-LOZENGE

2mg, 4 mg

Dose: 1 lozenge every 1-2 hrs.
Max: 20 pieces/day

Duration:
12 wks

NASAL SPRAY (Nicotrol® NS)

10 mg/ml

Dose: 1-2 doses per hr.
Max: 5 doses/hr or 40 doses/day

Duration:
3-6 mos

INHALER (Nicotrol® Inhaler)

Dose: 6-16 cartridges/day
Max: 16 cartridges/day

Duration:
3-6 mos

BUPROPION SR (Zyban®/ Wellbutrin SR®)

May be combined with nicotine replacement

150 mg tablets

Dose: 150 mg once per day (days 1-3)
150 mg twice per day (day 4+)
Max: 300 mg/day

Duration:
12 wks*

VARENICLINE (Chantix®)

0.5 mg, 1 mg tablets

Dose: Starting Month Pak =
0.5 mg once per day (days 1-3)
0.5 mg twice per day (days 4-7)
1 mg twice per day (days 8+)
Continuing Month Pak = 1 mg twice per day
Max: 2 mg/day

Duration:
12 wks*

** If quit at 12 wks, consider 12 more weeks of drug*

Source: Fiore MC, Jaen CR, Baker TB, et al. *Treating Tobacco Use and Dependence: 2008 Update. Quick Reference Guide for Clinicians*, Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. April 2009. Inclusion of this adult dosage chart is strictly for the convenience of the prescribing provider. Please consult the Physicians' Desk Reference for complete product information and contraindications. For insurance benefit information, the patient will need to contact his/her insurer directly. The cost or provision of these medications is not included as any part of the Rhode Island Smokers' Helpline or QuitWorks-RI program. Many health plans cover some or all medications. Patients should consult with insurer for details.

