Tobacco Exposure Screening & Action Form

Step 1: For you to fill out.

Date: _____ Patient's Name: _____

Relationship to Patient (circle one):

Mother *Father* *Other:* _____

Does your child live with anyone who smokes tobacco?

Yes *No*

If yes, who? _____

Have you used a tobacco product or vaping product, even a puff in last 7 days?

Yes *No, quit in past year* *No, quit over a year ago* *No, never*

If you smoke, how interested are you in quitting?

A lot Some A little Not at all

If you smoke, do you want to learn about resources to help you quit?

Yes No Not sure

Does anyone smoke or vape in your home ever?

Yes *No*

Does anyone smoke or vape in your car ever?

Yes *No* *No car*

Step 2: For the doctor/nurse to fill out

Provider Interventions :

☐ Advise establishing tobacco free home and car

☐ Advise to quit smoking

☐ Provide TN Quitline card, explain service

☐ Fax referral to TN Quitline service

☐ Provide CEASE brochures

☐ Discuss and set quit date:

_____

Progress Notes:

___/___/___ : _____

_____

___/___/___ : _____

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___/___/___ : _____

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