Huron County Health Unit

**5A Tobacco Use Intervention: ASK, ADVISE, ASSESS, ASSIST, ARRANGE**

**Client’s Name:**  **Chart Name**, **I.D. # or D.O.B:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ASK:** *“Have you used any form of tobacco products in the last 6 months?”*

**Yes**  **No**   **Not Asked**

If yes, *“What type of tobacco do you use?”*

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**ADVISE:** *“As your health care provider I am concerned with your smoking* (relate to their health status and/or risk

factors) *and would strongly advise you to quit using tobacco. It is the single most effective thing you can do to*

*improve your health and well being.”*

OR

*“As your health care provider I am very concerned about your smoking and the effects* (relate to their health status

and/or risk factors) *for you and your baby/child(ren). The single most effective thing you can do to improve your*

*health and the health of your baby/child(ren) is to quit using tobacco.”*

**Advice given**  **Advice not given**

**ASSESS:** *“Would it be okay with you if we talked about your tobacco use?”*

**Permission granted**  **Permission declined**

*“How do you feel about your tobacco use?”*   
   
   
*“Have you ever thought about quitting?”* **Yes**  **No**

*“Have you ever tried to quit?”* **Yes**   **No**

If so, *“What helped you quit in the past?”*

**(\*Staff consider using *Helpful Counselling Tools* card *Readiness Ruler* and/or *Decisional Balance*\*)**

*“Are you ready to make a quit attempt?”* **Yes**   **No**  **Uncertain**

**ASSIST:**

For tobacco users **willing** to quit or **wanting more information** about quitting

Provide and review *Quit Kit* contents. **Accepted**  **Not Accepted**

Advise of availability of nicotine replacement therapy via the *STOP Study*.  
**Complete**   **Not Complete**   **N/A**

Advise of availability of physician prescribed pharmacotherapy via the *Ontario Drug Benefit Program*.  
**Complete**   **Not Complete**  **N/A**

For tobacco users **not** **willing** to quit

Offer booklet *For Smokers’ Who Don’t Want to Quit.* **Accepted**  **Not Accepted**

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**ARRANGE:**

Discuss supports available by *Smokers’ Helpline* pertaining to the needs of the client.

*“Would you like to receive a supportive call from Smokers’ Helpline?”* **Yes**  **No**

If yes,

* Initiate referral and fax to *Smokers’ Helpline* **Complete  Not Complete**
* Provide postcard. **Complete  Not Complete**
* Advise of *Smokers’ Helpline* phone number, 1-877-513-5333.

(Many people have cell phones and don’t answer a toll free number.) **Complete**  **Not Complete**

If no, provide *Smokers’ Helpline* contact information. **Accepted** **Not** **Accepted**

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 Signature of Health Unit Staff Date & Time