TITLE: EMPLOYEE APPLICATION FOR NICOTINE REPLACEMENT THERAPY FORM

This form is to be completed by employees who wish to take up the offer of two courses of 8 weeks free NRT

Please send to Regional Pharmacist by fax, email, internal mail or deliver in person.

Name of Employee: _____

Health Service: _____

Department: _____

Telephone: _____

Number of cigarettes smoked per day:

10 or fewer 11 – 20 21 – 30 31 or more

How soon after waking do you smoke your first cigarette?

Within 5 minutes 5 – 30 minutes 31 – 60 minutes

If you have used any previous forms of NRT, please list: _____

Are you on any other medications, please list: _____

Are you under the age of 18 years?	YES / NO
Have you had a myocardial infarction?	YES / NO
Are you affected by unstable angina?	YES / NO
Are you affected by severe arrhythmias?	YES / NO
Have you suffered a recent CVA / stroke?	YES / NO
Are you affected by severe psoriasis?	YES / NO
Are you pregnant?	YES / NO
Are you lactating?	YES / NO
Are you a non-smoker?	YES / NO
Do you suffer from a mental health condition that requires medication?	YES / NO
If you have answered 'yes' to any of the above, you will need to be assessed by your doctor and have a medical certificate stating that it is safe for you to use NRT.	

Please turn over

This is my:

☐ first free 8 week course of NRT from the Health Service

☐ second free 8 week course of NRT from the Health Service **and** it has been 1 month since my first 8 week free course.

- I have read and understand all of the information in this application.
- I smoke more than 10 cigarettes per day **or** have my first cigarette with 30 minutes of waking.
- I consent to the faxing of this form to the Regional Pharmacist (where applicable).
- I will read the consumer Medication Information (CMI) of receipt of the NRT.
- I am aware of the benefits of taking nicotine replacement therapy to assist me to quit smoking and wish to participate in the 8 weeks free NRT offer.
- I am aware that I can contact Quitline for assistance (137848) and access www.quitnow.info.au/ during work hours.

In order to measure the effectiveness of the NRT offer to employees as a smoking cessation aid we would like to phone you in six months time to follow up. I agree to participate in a follow up telephone call.

No ❑ Yes ❑ Please provide your contact phone number: _____

The information I have provided is true and correct. I consent to my manager being notified on completion of my course of NRT.

Name *(please print)*	**Signature**	**Date**

To be completed by Manager	
Employee Name	
Employee 'he' Number	
Name and signature of Manager	
Fax number of Manager	
Cost centre number	
Date	

To be completed by Staff Member	
Site for pharmacist to deliver NRT to:	
Postal address:	
Street address:	
I will pick up my NRT from the following pharmacy (please indicate)	

To be completed by Pharmacy						
NRT Dispensed	**7,14 or 21mg patches**	**2 or 4mg lozenges/gum**	**Name**	**Signature**	**Date**	**Cost**
4 weeks of free NRT provided						
4 weeks of free NRT provided						
Please send a copy of the completed form to the Employee's line manager.						

This information is available in alternative formats upon request