

Tobacco Exposure Screening & Action Form

Step 1: For you to fill out.

Date: _____ Patient's Name: _____

Relationship to Patient (circle one):

Mother *Father* *Other:* _____

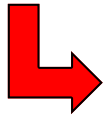
Does your child live with anyone who smokes tobacco?

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:

___/___/___ : _____

___/___/___ : _____

___/___/___ : _____
