

Relapse Prevention

You've done great so far. It's helpful to think about a few things to help you to continue reducing or staying quit. Do you think any of the following might be a problem for you?

Problems	Responses
<input type="checkbox"/> Do you have enough support for quitting smoking? <input type="checkbox"/> No _____→ <input type="checkbox"/> Yes ↓	<input type="checkbox"/> Would it be helpful to touch base by phone for extra support? <input type="checkbox"/> Can you identify anyone that can provide support for you? <input type="checkbox"/> You might want to call the Smokers' Helpline for extra support or see your family doctor.
<input type="checkbox"/> Is negative mood or depression a problem for you while quitting? <input type="checkbox"/> Yes _____→ <input type="checkbox"/> No ↓	<input type="checkbox"/> If you are having a lot of trouble with your mood, do you think you might want to see your family doctor for some help? _____ _____ _____
<input type="checkbox"/> Are you experiencing strong or prolonged withdrawal symptoms? <input type="checkbox"/> Yes _____→ <input type="checkbox"/> No ↓	<input type="checkbox"/> If you are experiencing prolonged craving or other withdrawal symptoms, you may want to look at your NRT dose. Do you think you need a higher dose of NRT? <input type="checkbox"/> YES ○ Adjust the dose and type of NRT dispensed. <input type="checkbox"/> NO ○ How else might you cope with these cravings?
<input type="checkbox"/> Have you experienced any weight gain or anticipate gaining weight because of quitting smoking? <input type="checkbox"/> Yes _____→ <input type="checkbox"/> No ↓	<input type="checkbox"/> Recommend starting or increasing physical activity; discourage strict dieting. <input type="checkbox"/> Reassure participant that some weight gain after quitting is common and appears to be self-limiting. <input type="checkbox"/> Emphasize the importance of a healthy diet. <input type="checkbox"/> Maintain the participant on NRT. <input type="checkbox"/> Refer the participant to a specialist or program.
<input type="checkbox"/> Are you experiencing low motivation to continue quitting or are you feeling deprived? <input type="checkbox"/> Yes _____→ <input type="checkbox"/> No	<input type="checkbox"/> Reassure the participant that these feelings are common. <input type="checkbox"/> Recommend rewarding activities. <input type="checkbox"/> Probe to ensure that the participant is not engaged in periodic tobacco use. <input type="checkbox"/> Emphasize that beginning to smoke (even a puff) will increase urges to smoke and make quitting more difficult.

Notes: _____

Schedule next appointment: _____

Signature: _____ Date: _____
dd/mm/yyyy