Smoking Assessment

Resident Name _____ Date _____

How many years have years have you been smoking? _____

What is the average number of cigarettes you smoke per day? _____

How soon after you wake in the morning do you need to smoke? _____

Within 30 Min. _____ Between 31 & 60 Min. _____ After 60 Min. _____

Do you wake up in the night with a strong desire to smoke? Yes _____ No _____

After meals do you have a strong desire to smoke? Yes _____ No _____

Do you become agitated if you are unable to smoke? Yes _____ No _____

If you answered Yes to the above question of agitation, please explain:

_____

_____

SAFETY:

Have you ever received a skin burn or burned your clothing with a lit cigarette?

Yes____ No____ If yes to above question, please explain _____

***Nursing Documentation*:**

Is Resident able to smoke independently?

Is Resident willing to smoke in designated smoking areas?

Will Resident's cigarettes be kept on Medication cart and handed out by staff?

Is Resident high risk for smoking in his/her private room?

Does MD agree with above assessment?

Is Resident willing to undergo process of quitting smoking?

Does the Resident use Oxygen? Yes _____ No _____ Continuous? _____
PRN? _____

Additional Comments _____

_____

Nursing Signature _____ Date _____