MY PERSONAL QUIT SMOKING PLAN

Today, I'm making a plan to change my life. I have decided to quit smoking, and my plan is outlined on this page. With the encouragement of my family and friends, and resources provided by my healthcare professional(s), I know I'll have the support I need to help me make this important, healthy change in my life.

FOR PATIENTS:

Complete this plan with your healthcare professional. Take it home to serve as a reminder or share it with family and friends.

FOR HEALTHCARE PROFESSIONALS:

Complete this plan together with your patient, and include a copy in the patient's chart.

PATIENT NAME: ____________________ DATE: ____________________

1 WHAT ARE THE MAIN REASONS WHY I HAVE DECIDED TO QUIT SMOKING?

(eg, my health, my family, financial)

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2 WHAT ARE SOME THINGS THAT HAVE PREVENTED ME FROM QUITTING IN THE PAST?

(eg, stress, habit, social settings)

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3 HERE ARE A COUPLE OF THINGS THAT MIGHT MAKE ME WANT TO SMOKE:

- ☐ Waking up
- ☐ Coffee
- ☐ Driving in the car
- ☐ Breaks after meals
- ☐ Alcohol
- ☐ Boredom
- ☐ Other: ____________________

4 WHAT CHALLENGES WILL I FACE IN THE NEXT FEW MONTHS THAT MIGHT AFFECT MY QUIT?

(eg, family event, fear of failure, fear of weight gain, stress)

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5 WHAT STRENGTHS DO I HAVE THAT WILL HELP ME SUCCEED?

(eg, I am strong-willed, goal-oriented)

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6 IF I FEEL THE URGE TO SMOKE, INSTEAD I WILL:

(eg, use nicotine replacement therapy, drink a glass of water, count to 20)

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7 MY DAILY AFFIRMATION OR NEW WAY OF THINKING CAN BE:

(eg, smoking isn't an option, I see myself as a nonsmoker)

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8 MY NEW BEHAVIOR:

(eg, alter routines, plan ahead, keep busy)

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WHICH NICOTINE REPLACEMENT TREATMENT IS RIGHT FOR ME?

For steady nicotine levels that last all day:

NICODERM® CQ® PATCH

☐ › 21 mg ☐ › 14 mg

For relief right when a craving hits:

NICORETTE® GUM

☐ › 4 mg ☐ › 2 mg

NICORETTE® LOZENGE

☐ › 4 mg ☐ › 2 mg

NICORETTE® *MINI* LOZENGE

☐ › 4 mg ☐ › 2 mg

Read and follow label directions. Behavioral support increases chances of success. Refer to downloadable dosing information for complete product dosing.

☐ OTHER: ______________________________

9 WHO WILL SUPPORT MY EFFORTS TO QUIT?

(eg, family/friends, healthcare professional(s), websites, phone quit lines, quitting brochures)

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10 HOW WILL THEY SUPPORT ME?

(eg, phone calls, positive e-mails, listening)

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11 MY NEXT STEPS AND WHEN I WILL DO THEM:

(eg, tell my friends/family, clean my car)

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12 AT MY FOLLOW-UP APPOINTMENT WITH MY HEALTHCARE PROFESSIONAL, WE WILL:

(eg, review medication, discuss challenges, celebrate successes)

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On this day, ______________________________, I agree to start living a smoke-free life.

Signed: ______________________________

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