ASSESSMENT & ENCOUNTER CHECKLIST*

	Patient Status					
Date of Patient Encounter:						
All Patients: **(See also section 3.2 *Assessment of Tobacco Use and Exposure*)**						
Ask about tobacco use currently and historically.						
Ask about respiratory symptoms or other tobacco-related symptoms.						
Ask about risk factors – personal, familial, and environmental.						
Ask about history of current depression, panic attacks, and PTSD.						
For Patients Who Are Current Tobacco Users:						
Measure nicotine dependence severity (FTND)						
Measure nicotine withdrawal symptoms (NWS)						
Tobacco-Dependence Treatment Progress: **S** – Treatment Successful; patient not smoking. **I** – Treatment Initiated/In process. Discuss what is working, what is not, how to make changes. **LM** – Patient has lost motivation. Explain that most who successfully stop tobacco use have tried three or more times previously. This is not a failure, just one step on the road to eventual success. Provide motivational patient education materials.						
For Patients Who Are Former Tobacco Users:						
Measure nicotine withdrawal symptoms (NWS)						
Is the patient continuing to be tobacco-free? **Yes** –Not smoking at all **No** – Lapse/Relapse Reassess treatment plan and revise pharmacological or behavioral management, or both. Provide motivational patient education materials.						
All Patients:						
Assess whether the patient needs spirometry and review of his or her "Lung Age."**						
Assess whether to measure SpO_2						
Update Medical Problem List for all current diagnoses*						
Update and revise medical treatment plan for all diagnoses, including tobacco dependence, as needed*						

* **See Section 1.3 Billing and Coding** for instructions on how to determine and apply correct ICD-9_CM diagnostic codes and CPT E/M codes.

** See **Lung Age** section in §1.6 Treatment Process and Approach