Appendix C – Varenicline Clinical Risk Assessment Form

Pharmacy Stamp:	Name: Address: Telephone number: Date of Birth: GP Name and Address:

Factor	Yes	No	Notes
Is person under 18 years of age			If ' yes' - refer
Is person pregnant or breastfeeding?			If ' yes' – refer`
Does person suffer from renal impairment or has end stage renal disease?			If ' yes'- refer
Does person have a history of psychiatric illness			If ' yes' – refer to PGD and monitor patient closely
Does person suffer from epilepsy?			If ' yes' - refer
Is person currently on another smoking cessation therapy?			If ' yes' - refer
Is person on any other medication?			Please list. Check PGD for interaction
Is person hypersensitive to varenicline or any of its excipients?			If ' yes' - refer

Special circumstances and any other relevant notes:

Only make a supply if you are certain that to the best of your knowledge, it is appropriate to do so.

Action taken:

Supply:

Referral to:

Advice given:

The above information is correct to the best of my knowledge. I have been counselled on the use of varenicline and understand the advice given to me by the pharmacist. **Signature:** **Date:**	The action specified was based on the information given to me by the person, which, to the best of my knowledge, is correct. **Pharmacist's Signature:** **Date:**