MRN	Title	Sex	DOB
Surname		Given Names	
Address		Suburb and Postcode	
Phone (h)		Phone (w)/ Mobile	

Dear _____ .

_____ has indicated their interest in quitting smoking.

Assessment of nicotine dependence for this patient is as follows:

Hooked On Nicotine Checklist Score	Fagerstrom Test for Nicotine Dependence Score /10	CO Reading	Time to first cigarette	No. of cigarettes per day

Indicating a **high, moderate, low** level of dependence on nicotine.

This patient has been commenced on the following medications to treat nicotine dependence:

_____

_____

_____

_____

_____

_____

If you would like more information on the treatment and management of nicotine dependence for this patient, please contact:

_____

Yours Sincerely