Smoke-Free Pregnancy Program

Referring Provider | Organization: _____

Referring Provider Phone: _____

Please fax completed referral form to: Community Cancer Center Attn: Angelia Freeman, 541-672-9483

Personal Information:

Name: _____ Phone: _____

Mailing Address: _____ Zip code: _____

Email: _____ How many commute miles to workshop: _____

Date of Birth: _____ Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Non-Binary ☐ Prefer not to respond

What is the highest grade of school that you have completed? _____ Annual Household Income: _____

Are you currently pregnant or are attempting to become pregnant? _____ If so, what is your due date: _____

Name of obstetrician: _____

Please select the race/ethnic identity, tribal affiliation, country of origin, or ancestry which best describes you:

☐ African American
☐ Asian | Pacific Islander
☐ Alaska Native
☐ Caucasian
☐ Cuban
☐ East Indian
☐ Hispanic | Latino | Mexican
☐ Native American
☐ Ethnoreligious
☐ Mixed
☐ Other
☐ Prefer not to respond

Tell Us About Your Nicotine Habit:

1. When did you first start using tobacco products (age)? _____ 2. How long have you used tobacco products? _____

3. What form of tobacco products do you currently use? _____ 4. How long was your longest quit attempt? _____

5. How many packs of cigarettes, vape cartridges, or cans of chewing tobacco do you smoke/use per week? _____

6. # of past quit attempts: _____ 7. Do you currently smoke cigarettes, use chewing tobacco, or use nicotine delivery devices? _____

If yes to question #7, please read each question in the next section. For each question, enter the answer choice which best describes your response.

Fagerstorm Test for Nicotine Dependence (FTND)

1. How soon after you wake up do begin using tobacco products?

☐ Within 5 minutes ☐ 6 - 30 minutes ☐ 31 - 60 minutes ☐ After 60 minutes

2. Do you find it difficult to refrain from tobacco use in places where it is forbidden (e.g., in church, at the library, in the cinema)?

☐ No ☐ Yes

3. Which incident of tobacco use would you hate most to give up?

☐ First thing in the morning ☐ Any other

4. How many times per day do you use any form of tobacco/nicotine?

☐ 10 or less ☐ 11 - 20 ☐ 21 - 30 ☐ 31 or more

5. Do you use tobacco/nicotine more frequently during the first hours after waking than during the rest of the day?

☐ No ☐ Yes

6. Do you use tobacco/nicotine products when you are so ill that you are in bed most of the day?

☐ No ☐ Yes

ONLINE REGISTRATION AVAILABLE

Your score (your level of dependence on nicotine) is: _____

Community Cancer Center

DOUGLAS PUBLIC HEALTH NETWORK

Thrive Umpqua