



MY CHANGE PLAN



NAME _____ CHANGE DATE _____

REASONS
FOR CHANGE _____

MY SMART
HEALTH
GOAL _____

MY COPING STRATEGIES

When in this situation...

I will...

Severe Triggers		
Moderate Triggers		
Mild Triggers		

MY SUPPORTS

I will contact...

When I feel...

--	--

MY PROGRESS

I will track my progress by...

--



MY CHANGE PLAN



MY NRT	Dose	To be taken
<input type="checkbox"/> Patch		
<input type="checkbox"/> Gum		
<input type="checkbox"/> Lozenge		
<input type="checkbox"/> Spray		
<input type="checkbox"/> Inhaler		

MY PRESCRIPTIONS	Dose	To be taken
Varenicline (Champix®)		
Bupropion (Zyban®)		
OTHER PRESCRIPTION		

MY TIPS From my educator

MY WAYS TO CELEBRATE OR REWARD MYSELF

When I have...	I will...

MY CERTIFIED TOBACCO EDUCATOR _____ **CONTACT** _____

My Next Appointment _____