NEAR EAST UNIVERSITY HOSPITAL

PATIENT INFORMATION AND CONSENT FORM FOR SMOKING CESSATION THERAPY

Unit Name		**Date**	
Patient's Full Name		**Protocol No**	
Date of Birth		**Early Diagnosis**	

Dear Patient/Legal Representative,

It is your decision whether to consent to the recommended smoking cessation therapy after being informed about the treatment, including its benefits and potential risks. You have the right to withdraw from the treatment at any stage of the process if you wish.

This document, which we ask you to read, is not intended to alarm you or deter you from any medical procedures. Instead, it is prepared to provide you with information to help you decide whether or not to give your consent for the proposed procedures and to obtain your approval.

Your treatment will be conducted by a specialist in Pulmonology. The treatment duration is planned to be approximately 8-12 weeks. However, your doctor may decide to shorten or extend this period. During the treatment, your doctor may require certain blood tests and additional examinations at specified intervals. Based on the results obtained, adjustments to the treatment method or dosage may be made.

With smoking cessation therapy, you will overcome nicotine dependence. Within the first 24 hours of quitting smoking, lung function begins to improve. Your sense of smell and taste will improve, and the repair process of damaged nerve endings will start.

In the first 2-12 weeks, heart rate, blood pressure, and circulation will begin to improve, and the risk of heart attack will decrease. After one year, your risk of heart attack will be reduced by half compared to that of a smoker. After five years, the risk of cancers of the head, neck, and bladder will decrease by 50%, the risk of cardiovascular disease will approach that of non-smokers, and the risk of cervical cancer and stroke will be similar to that of individuals who have never smoked. After ten years, the risk of lung cancer will be halved, and the risk of cancers of the larynx and pancreas will be reduced.

In addition to the health benefits, quitting smoking will also bring social advantages, such as the elimination of bad odors from the mouth and clothing, financial savings, setting a good example for children and young people, and increased self-confidence.

If deemed necessary by your doctor, a psychiatric consultation may be required before starting medication. This consultation is especially recommended for individuals who are using psychiatric medications (such as antidepressants, antipsychotics, etc.). The purpose of the consultation is to evaluate whether the smoking cessation therapy might have a negative impact on your psychiatric condition.

During smoking cessation therapy, medication alone is not sufficient. You must also implement the behavioral changes recommended by your doctor. For individuals who prefer not to use medication or have conditions that prevent the use of medication, alternative treatments such as Acupuncture Therapy may be considered.It is essential that each patient receives and follows a treatment plan tailored to their needs for smoking cessation (nicotine addiction treatment). Below, the risks and complications of the medications are discussed.

- Zyban (bupropion): This medication reduces withdrawal symptoms and cravings during the smoking cessation process. It has side effects including insomnia, nausea, tremors, and dry mouth. It should not be used by individuals with epilepsy, uncontrolled hypertension, a history of severe psychiatric disorders with delusions or hallucinations (such as psychotic disorders or schizophrenia), a history of bipolar disorder (manic episodes), or those diagnosed with anorexia characterized by excessive weight loss. Additionally, it is not recommended for patients under 18 years of age.
- Champix (varenicline): This medication is most commonly associated with side effects such as nausea, constipation, changes in appetite, and abnormal dreams. It is contraindicated in patients with severe depression and those with severe renal impairment. It should not be used by individuals with a history of depression, bipolar disorder (depressive and manic episodes), panic disorder, psychotic disorders (including delusions or hallucinations), anger management issues, suicidal thoughts or behaviors, or those who develop these symptoms after starting the medication. Additionally, it is not recommended for patients under 18 years of age. Due to potential adverse effects on the cardiovascular system, inform your doctor if you have a known history of cardiovascular disease.
- Nicotine patches or nicotine replacement products (Nicorette, Nicotinell, etc.): These products are contraindicated in individuals with severe allergic reactions to nicotine or other components of the nicotine replacement preparations. They are also contraindicated in individuals who have experienced a serious stroke, myocardial infarction, unstable angina, arrhythmia, coronary bypass surgery, coronary angioplasty, or similar procedures within the past 4 weeks. For individuals with cardiovascular disease, consultation with a specialist may be required depending on the clinical setting. In cases of renal failure, liver failure, ulcer disease, hyperthyroidism,pheochromocytoma, diabetes mellitus, and similar conditions, nicotine patches and replacement products should be used cautiously and with careful consideration of the risk-benefit ratio. Some nicotine patches and replacement products contain metal components and should be removed prior to magnetic resonance imaging (MRI) or similar imaging techniques. These products are contraindicated in patients with psoriasis, urticaria, dermatitis, or other chronic dermatological conditions. In the case of chronic medication use, caution is advised regarding potential interactions with the components of nicotine patches and replacement products, and their use may need to be reconsidered. These products are classified as Category D for pregnancy, indicating potential risks to the fetus. Common side effects include dizziness, headaches, insomnia, palpitations, gastrointestinal disturbances, nausea, vomiting, erythema, itching, urticaria, aphthous ulcers, and skin reactions, with some occurring more frequently than others. In such cases, the patient's condition should be evaluated by a doctor, and nicotine patch therapy should be discontinued if necessary. Nicotine poisoning can occur with nicotine replacement product use or excessive dosing, presenting symptoms such as nausea, abdominal pain, dizziness, sweating, increased salivation, convulsions, hearing problems, hypotension, diarrhea, pulse

irregularities, and others. It is crucial to use these products only at the dose and frequency recommended by your doctor. In the event of nicotine poisoning, contact your doctor or go to the nearest healthcare facility. Nicotine patches and replacement products, as well as their waste, should be kept out of reach of children. Products intended for adults can cause serious poisoning in children.

I have read the information provided above and/or my relative has read it to me. I have been informed by the doctor whose signature appears below about the name, purpose, risks, complications, and additional treatment requirements of the procedure. I have been given sufficient time to ask questions and make a decision regarding this medical procedure, and I have been provided with a copy of this patient consent form. I have been informed that the results of this intervention may not be successful. Without requiring any further explanation, and without being under any pressure, I consent to this procedure knowingly and voluntarily.

In the event of loss of consciousness or inability to give consent during my diagnosis and treatment, I appoint the person named ..... to make decisions and obtain any necessary information regarding my treatment (The person appointed by the patient must sign as the patient's representative/legal representative).

…….

[Write "I HAVE READ, UNDERSTOOD, AND ACCEPT" in your own handwriting]

Patient's Full Name (in handwriting)	**Signature**	**Date/Time**
Name of Patient's Representative/Legal Representative (in handwriting) *NOTE: The signature of the representative/legal representative is required if the patient is unable to give consent.*	**Signature**	**Date/Time**
Doctor's Name (in handwriting)	**Signature**	**Date/Time**

Notes:

1. If the patient is under 18 years old, unconscious, or unable to sign, consent is given by a representative.
2. This form is completed in 2 copies; one copy remains with the patient.