Smoke Free for Me

Ohio Chapter
INCORPORATED IN OHIO
American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

If caregiver is 18 or older and unless otherwise noted, please select 1 response per question.

(1) Visit date: *(MM-DD-YY)* ☐☐-☐☐-☐☐

(2) Is this a 0-12 month well-baby visit? ○ Yes - Continue to **(3)**. ○ No STOP - ***Do not*** continue the form.

(3) Have you ever completed this form? *If unsure, select No and continue to* ***(4)***. ○ Yes STOP - ***Do not*** continue the form. ○ No - Continue to **(4)**.

(4) Does your baby **ever** nap or sleep in any of the following ways: *(Select yes or no for each way.)*

a) with an adult in bed or on a couch	Yes ○	No ○
b) somewhere other than a crib	Yes ○	No ○
c) on their side or belly	Yes ○	No ○
d) with things in their crib like bumpers, toys, or blankets	Yes ○	No ○

(5) In the past 7 days, did **you**: *(Select all that apply.)* Smoke ☐ Vape ☐ Did not smoke/vape ☐

(5a) **If you smoked or vaped in the past 7 days**, on a scale from 0-10, what number shows your thoughts about quitting?

No thought of quitting now		*Should consider quitting someday*		*Should quit but not quite ready*		*Thinking about cutting down or quitting*		*Have cut down and seriously considering quitting*		*Ready to quit*
0	1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○	○

(6) Do **others** who live in the home with the baby currently smoke or vape? Yes ○ No ○

If you answered *Yes* in questions (4) or (6) above, or you smoke/vape, please continue.

(7) Baby's date of birth: *(MM-DD-YY)* ☐☐-☐☐-☐☐

(8) Baby's race: *(Select all races that apply.)*

☐ African American or Black ☐ White ☐ Hispanic or Latino
☐ American Indian or Alaskan Native ☐ Asian ☐ Other

(9) Your relationship to the baby: *(Select relationship to the baby of only one person.)*

○ Mother ○ Father ○ Legal Guardian ○ Other

(10) Your age: (*Round down. For example, if you are 35 1/2, select* 26-35.)

○ 18-25 ○ 26-35 ○ 36-45 ○ 46+

(11) Your current insurance type: *(Select all insurance types that apply.)*

☐ Medicaid ☐ Medicare ☐ Other ☐ Self-pay

Caregiver *STOP* survey. Office staff/provider to complete below if positive screen to (4), (5), or (6)

I	**If yes to any of the above in (4)**, was there an attempt to address safe sleep?	Yes ○ No ○
II	**If smoking/vaping in (5) or (6)**, was there an attempt to discuss household smoking/vaping risks for the baby?	Yes ○ No ○
III	**If smoking/vaping in (5)**, was there an attempt to share tobacco cessation education resources?	Yes ○ No ○
IV	**If smoking/vaping in (5)**, was there an attempt to offer a referral? *Recommended for caregivers who indicate willingness to quit with (5a) quit thoughts ≥2.*	Yes ○ No ○

Site ID: ☐☐