The Association for the Treatment of Tobacco Use and Dependence (ATTUD) Recommendation for Recording Smoking Status and Passive Smoke Exposure in the Electronic Health Record

The major concern with the current smoking status classifications in the electronic health record (EHR) is that **the choices are not mutually exclusive. This creates confusion at the point of care when smoking status is documented**.

Overlap and confusion is created by:

- Vagueness of "some day" smoker (i.e. what frequency).
- Vagueness of "heavy" and "light" smoker (i.e. number of cigarettes/day).
- Vagueness of "former smoker" (i.e. how long since quit).
- Each patient is documented with one smoking status which creates overlap:
    - "Current every day smoker" and "light smoker".
    - "Current every day smoker" and "heavy smoker".
    - "Current some day smoker" and "light smoker".
- Uncertainty that all clinical staff who are identifying and documenting patient smoking status are using consistent definitions for each category.

To **simplify, publicize, and promote non-overlapping criteria for smoking status documentation** in the EHR, the smoking status classifications that we recommend ATTUD members use are:

Smoking Status	SNOMED CT Code
Current Every Day Smoker	449868002
Current Some Day Smoker	428041000124106
Former Smoker	8517006
Never Smoker	266919005
Smoking Status Unknown	266927001

Passive smoke exposure documentation simplification

Passive Smoking Exposure	SNOMED CT Code
Exposure to Second Hand Tobacco Smoke	16090371000119103
Past Exposure to Second Hand Tobacco Smoke	99009004
No Known Exposure to Second Hand Tobacco Smoke	711563001

For clarification and simplicity, we recommend that all ATTUD members in their clinical practice use the above smoking status classifications for active and passive smoking.

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