APPENDIX 1. **Details measurements for the process evaluation among practice nurses and people who smoke and the effect evaluation among people who smoke**

Measurements	Answer categories	Other information
Process evaluation		
Usage ("did you use/see the the manual/ website/ placemat / poster/ flyer/ the waiting room screen")	0 = no 1 = yes	among PNs from the subsample and people who smoke who took part in the experimental condition.
Appreciation of the materials ("'I Think the referral aids materials are clear/understandable/educational")	(1 = strongly disagree; 5 = strongly agree).	
Overall rating of the intervention materials	on a scale from 1 to 10 (1 = very bad; 10 = very good).	
Demographic information		
Age	Open ended	N/A
Gender	0 = male 1 = female 3 = Not on the list/Prefer not to say	N/A
Education	1 = low: no education, primary, or basic vocational school 2 = medium: secondary vocational school or high school 3 = high: higher vocational school or university	N/A
Health status		
Do you currently have COPD / cancer / type 2 diabetes / cardiovascular diseases/ asthma / depression	0 = yes 1 = no	N/A
Smoking behavior		
Number of cigarettes smoked per day	Continuously	N/A
The current use of e-cigarettes	1 = no 2 = yes, without nicotine 3 = yes, with nicotine	N/A
Cigarette dependence	Assed via the the Fagerström Test for Cigarette Dependence (60,61)	The six items of the scale were converted into an overall score ranging from 0 to 10.
Previous cessation attempts	0 = yes 1 = no	
Stage of decision making to quit smoking	1 = yes, within one month 2 = yes, within three months 3 = yes, within six months 4 = yes, within one year 5 = yes, but not within one year 6 = no, I do not plan to quit smoking).	

6-month follow-up		
Use of EBSCIs at cessation attempt	Counseling in the GP-setting, counseling by a coach, eHealth, group counseling, telephone counseling, NRT, pharmacotherapy and other non-EBSCIs	
Decisional conflict ('I feel I have made an informed choice')	assessed via the decisional conflict scale (DCS), using 16 items on a 5-point Likert scale (1 = strongly disagree; 5 = strongly agree)	to find out whether decisional conflict played a role in choosing a fitting EBSCI (49,62).
24-hour point prevalence abstinence	Total abstention, meaning refraining from even a single puff, within 24-hours	As previously used in (63–65)
7-day point prevalence abstinence	Total abstention, meaning refraining from even a single puff, within 7 days	As previously used in (63–65)
6-months prolonged abstinence	After an initial grace period, practicing complete abstinence (including refraining from even a single puff)	As previously used in (63–65)
'bogus pipeline' question ('Will you object, if we visit you for a saliva test to check your smoking status?')	Yes/no	to reduce socially desirable responses by including the threat of biochemical testing (66,67).

ndix 2. CONSORT 2010 checklist of information to include when reporting a randomised trial*

Section/Topic	Item No	Checklist item	Reported on page No
Title and abstract			
	1a	Identification as a randomised trial in the title	1
	1b	Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts)	2
Introduction			
Background and objectives	2a	Scientific background and explanation of rationale	3
	2b	Specific objectives or hypotheses	3
Methods			
Trial design	3a	Description of trial design (such as parallel, factorial) including allocation ratio	6-8
	3b	Important changes to methods after trial commencement (such as eligibility criteria), with reasons	8
Participants	4a	Eligibility criteria for participants	6
	4b	Settings and locations where the data were collected	6
Interventions	5	The interventions for each group with sufficient details to allow replication, including how and when they were actually administered	7
Outcomes	6a	Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed	7-8
	6b	Any changes to trial outcomes after the trial commenced, with reasons	n/a
Sample size	7a	How sample size was determined	Protocol paper
	7b	When applicable, explanation of any interim analyses and stopping guidelines	n/a
Randomisation:			
Sequence generation	8a	Method used to generate the random allocation sequence	Protocol paper
	8b	Type of randomisation; details of any restriction (such as blocking and block size)	Protocol paper

Allocation concealment mechanism	9	Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned	Protocol paper
Implementation	10	Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions	Protocol paper
Blinding	11a	If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) and how	Protocol paper
	11b	If relevant, description of the similarity of interventions	n/a
Statistical methods	12a	Statistical methods used to compare groups for primary and secondary outcomes	7-8
	12b	Methods for additional analyses, such as subgroup analyses and adjusted analyses	n/a
Results			
Participant flow (a diagram is strongly recommended)	13a	For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome	8-10
	13b	For each group, losses and exclusions after randomisation, together with reasons	n/a
Recruitment	14a	Dates defining the periods of recruitment and follow-up	8-10
	14b	Why the trial ended or was stopped	8-10
Baseline data	15	A table showing baseline demographic and clinical characteristics for each group	8-10
Numbers analysed	16	For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups	8-10
Outcomes and estimation	17a	For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval)	n/a
	17b	For binary outcomes, presentation of both absolute and relative effect sizes is recommended	n/a
Ancillary analyses	18	Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory	n/a
Harms	19	All important harms or unintended effects in each group (for specific guidance see CONSORT for harms)	n/a
Discussion			
Limitations	20	Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses	11-14
Generalisability	21	Generalisability (external validity, applicability) of the trial findings	11-14
Interpretation	22	Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence	11-14
Other information			
Registration	23	Registration number and name of trial registry	2
Protocol	24	Where the full trial protocol can be accessed, if available	2

Funding	25	Sources of funding and other support (such as supply of drugs), role of funders	14

*We strongly recommend reading this statement in conjunction with the CONSORT 2010 Explanation and Elaboration for important clarifications on all the items. If relevant, we also recommend reading CONSORT extensions for cluster randomised trials, non-inferiority and equivalence trials, non-pharmacological treatments, herbal interventions, and pragmatic trials. Additional extensions are forthcoming: for those and for up to date references relevant to this checklist, see www.consort-statement.org.