

Symptom Assessment Scale



Instructions:

- Score at episode start, at phase change, at episode end, and as clinically required/indicated.
- Assessment may be recorded daily for 1 or 2 troublesome symptoms.
- Symptoms are rated by the patient/client except where they are unable due to language barrier, hearing impairment or physical condition such as terminal phase or delirium, in which case a proxy is used. Use the most appropriate proxy. This may be the nurse or the family member.
- Highly rated or problematic symptoms may trigger other assessments or clinical interventions

As part of your assessment inform the patient that you are going to ask them about the symptoms they may be experiencing or the symptoms that are causing a problem.

When asking about these symptoms for the first time say:
 I'm going to ask you about some common symptoms you may be experiencing. We would like to know how much they affect you by rating them with a number from 0-10
 Can you think about how you have felt over the last 24hrs and when I ask you about your symptoms can you rate them by giving a score of 0 to indicate that you are not having a problem with that symptom, 10 to indicate you are having the worst possible problem and numbers 1 through to 9 indicate somewhere in between, just pick the number that best describes how you feel

Please note: Where the person has multiple pains assess each one separately
 If the person has additional symptoms add these in the blank rows

<i>Date</i>																			
Insomnia																			
Appetite Problems																			
Nausea																			
Bowel Problems																			
Breathing Problems																			
Fatigue																			
Pain																			
Completed by: N = Nurse D = Doctor F = Family P = Patient																			

References:

1. Kristjanson, L. J. Pickstock, S., Yuen, K., Davis, S., Blight, J., Cummins, A., et al. (1999). *Development and testing of the revised Symptom Assessment Scale*. Perth: Edith Cowan University.
2. Nightingale, E., Yuen, K., Firms, P., Duggan, G., Cummins, A., Kristjanson, L. J., et al. (2000). *Evaluation of a goal specific care model*. Perth: The Cancer Foundation Centre for Palliative Care.
3. Toye, C., Walker, H., Kristjanson, L. J., Popescu, A., & Nightingale, E. (2005). Measuring symptom distress among frail elders capable of providing self reports. *Nursing & Health Sciences*, 7(3), 184-191.

