NCCA National Office of Clinical Audit

PCOCI Palliative Care Outcomes Collaboration Ireland

(Please complete or affix label here)

MRN:
Surname
First name:
DOB:

Edmonton Symptom Assessment Scale

Please use this form to tell us about your symptoms and concerns. This information will help us to best manage your care.

0 Dark green - no problem at all

1 Light green - a small problem, but it is manageable

5 Orange - a moderate problem and more difficult to manage

10 Red - a big problem and very difficult to manage.

1. Write the date in the first row.
2. Use the scale above to choose a number between 0 and 10 which shows the severity of the symptom or concern over the last 24 hours.
3. You can add other symptoms in the blank space at the bottom of the list.

Day or date								
Pain *(0 = no pain, 10 = worst possible)*								
Tiredness (lack of energy) *(0 = no tiredness, 10 = worst possible)*								
Drowsiness (feeling sleepy) *(0 = no drowsiness, 10 = worst possible)*								
Nausea *(0 = no nausea, 10 = worst possible)*								
Appetite *(0 = best appetite, 10 = worst possible)*								
Shortness of Breath *(0 = no shortness of breath, 10 = worst possible)*								
Constipation *(0 = no constipation, 10 = worst possible)*								
Sleep *(0 = best sleep, 10 = worst possible)*								
Depression (feeling sad) *(0 = no depression, 10 = worstpossible)*								
Anxiety (feeling nervous) *(0 = no anxiety, 10 = worst possible)*								
Wellbeing (how you feel overall) *(0 = best wellbeing, 10 = worst possible)*								
Other Symptom *(D = dry or sore mouth, I = Itch, S = Swallowing, Ot = Other, N = None)*								
Other Symptom Score *(0 = none, 10 = worst)*								
Rated By *(P = Patient, F = Family/Carer, C = Clinician, Ot = Other)*								