#### PALLIATIVE CARE ASSESSMENT FORM (sample assessment form)

**Instructions for Use:** Assess on admission, daily, at phase change and at discharge

<table>
<thead>
<tr>
<th>Date:</th>
<th>Time:</th>
</tr>
</thead>
</table>

**PHASE:**

<table>
<thead>
<tr>
<th>Problem Severity</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td></td>
</tr>
</tbody>
</table>

**Other Symptoms**

<table>
<thead>
<tr>
<th>Psychological/spiritual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family carer</td>
</tr>
</tbody>
</table>

**RUG ADL**

<table>
<thead>
<tr>
<th>Bed Mobility</th>
<th>Toileting</th>
<th>Transfer</th>
<th>Eating</th>
</tr>
</thead>
</table>

**Total RUG**

<table>
<thead>
<tr>
<th>Karnofsky Performance Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptom Assessment Scale</td>
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</tbody>
</table>

**Symptom Assessment Scale**

<table>
<thead>
<tr>
<th>Insomnia</th>
<th>Appetite Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea</td>
<td>Bowels</td>
</tr>
<tr>
<td>Breathing</td>
<td>Fatigue</td>
</tr>
<tr>
<td>Pain</td>
<td>Other:</td>
</tr>
</tbody>
</table>

**Reason for phase end**

**Model of Care at phase end**

**Staff Initials**
**PALLIATIVE CARE PHASE:**  
**Staff rated:**  
1. **STABLE:** Symptoms are adequately controlled by established management  
2. **UNSTABLE:** Development of a new problem or a rapid increase in the severity of existing problems  
3. **DETERIORATING:** Gradual worsening of existing symptoms or the development of new but expected problems  
4. **TERMINAL:** Death likely in a matter of days  
5. **BEREAVED:** Death of a patient has occurred and the carers are grieving

**RUG-ADL**  
**(Resource Utilisation Group – Activities of Daily Living)**  
**Staff rated:**  
For Bed Mobility, Toileting and Transfers  
1. Independent or supervision only  
2. Limited physical assistance  
3. Two or more person physical assist  
4. Other than two person physical assist  
5. Two or more person physical assist  
For Eating  
1. Independent or supervision only  
2. Limited assistance  
3. Extensive assistance/total dependence/tube fed

**REASON FOR PHASE END:**  
(the reason this phase ended)  
1. Phase Change  
2. Discharge/Case closure  
3. Died  
4. Bereavement phase end  
If the reason for phase change is bereaved, record 3 died. At the end of bereaved phase record 4

**MODEL OF CARE AT PHASE END:**  
(the type of care provided at the end of this phase of care)  
1. Direct Care  
2. Share care with another service provider(s)  
3. Consultation/liaison with another service provider

**AKPS**  
**(Australian modified Karnofsky Performance Scale)**  
**Staff rated:**  
100 Normal, no complaints or evidence of disease  
90 Able to carry on normal activity, minor signs or activity  
80 Normal activity with effort, some signs or symptoms of disease  
70 Care for self, unable to carry on normal activity or to do active work  
60 Occasional assistance but is able to care for most of his needs  
50 Requires considerable assistance and frequent medical care  
40 In bed more than 50% of the time  
30 Almost completely bedfast  
20 Totally bedfast & requiring nursing care by professionals and/or family  
10 Comatose or barely arousable  
0 Dead

**PROBLEM SEVERITY SCORE**  
**Staff rated:**  
For the following 4 items assess the severity of distress as:  
0 = Absent; 1 = Mild; 2 = Moderate; 3 = Severe  

**PAIN:**  
The degree of overall pain  

**OTHER SYMPTOMS:**  
Record the degree of overall other symptoms.  
The following list may be used as a guide:  
Nausea/vomiting; Anorexia; Itch/irritation; Constipation/diarrhoea; Wound/ulcer; Incontinence; Weakness/fatigue; Oedema; Dyspnoea; Confusion/delirium;  

**PSYCHOLOGICAL / SPIRITUAL:**  
Record the score for overall degree of psychological/spiritual problems of the patient  
The following list may be used as a guide:  
Anxiety/fear; Request to die; Anger; Depression/sadness; Unrealistic goals; Confusion; Agitation;  

**FAMILY / CARER:**  
Record score for the overall degree of family/carer problems.  
The following list may be a guide:  
Denial; Anger; Caregiver fatigue; Sensory impairment; Unrealistic goals; Financial; family/carer conflict; Difficult communication; Non-English speaking; Legal; Family/carer anxiety; Accommodation; Cultural;  

**SYMPTOM ASSESSMENT SCALE**  
**Patient rated:**  
The patient is asked to rate their experience of each symptom from 0 being none at all to 10 being worst possible.  
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 1st 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  
Where a person cannot rate the symptom, assign the number that most closely matches your clinical assessment. Alternatively you can ask a career to rate the severity of each symptom. This is called a proxy assessment.  

1. Insomnia  
2. Appetite problems  
3. Nausea  
4. Bowels  
5. Breathing  
6. Fatigue  
7. Pain