northern health
the northern way of caring

Patient name: _____
Address: _____
Date of birth: _____
Phone #: _____
PHN: _____
PATIENT LABEL

All Sites and Facilities

Symptom Assessment Acronym

Symptom: _____

Palliative Performance Scale%: _____ ☐ **Stable** ☐ **Slow decline** ☐ **Rapid decline** ☐ **Unknown**

O	**Onset** When did it begin? How long does it last? How often does it occur?	
P	**Provoking/palliating** What brings it on? What makes it better? What makes it worse?	
Q	**Quality** What does it feel like? Can you describe it (patient's own words)	
R	**Region/radiation** Where is it? Does it spread?	
S	**Severity** How severe is this symptom? What would you rate it on a scale 0-10 (0 being none and 10 being the worst possible)? Right now? At worst? On average? How bothered are you by this symptom? Are there any other symptom(s) that accompany this symptom?	
T	**Treatment** What medications and treatments are you currently using? Are you using any non-prescription treatments, herbal remedies, or traditional healing practices? How effective are these? Do you have any side effects from the medications and treatments? What have you tried in the past? Do you have concerns about side effects or cost of treatments?	
U	**Understanding** What do you believe is causing this symptom? How is it affecting you and/or your family? What is most concerning to you?	
V	**Values** What overall goals do we need to keep in mind as we manage this symptom? What is your acceptable level for this symptom (0-10)? Are there any beliefs, views or feelings about this symptom that are important to you and your family? What are you having trouble doing because of this symptom that you would like to do?	

Describe likely etiology of the symptom:

Physical findings/comments: _____

Signature / Designation: _____ **Date:** _____

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The Symptom Assessment Acronym Tool assists health care providers in completing a comprehensive symptom assessment when a patient identifies a symptom occurrence or experience to be distressing (e.g., a symptom severity score of 4 or greater, on a scale of 0-10). The acronym OPQRSTUV tool has been developed to help care providers collect relevant information systematically when completing a symptom assessment. Physical symptoms may include dyspnea, constipation, nausea, fatigue, and etc.

Instructions:

1. Symptom assessment should be completed by the primary care provider on admission to all sites/programs and then as needed. Use a separate form for each symptom.

2. In addition, a symptom assessment should be completed if there is a significant change in a previously identified symptom, any modification to the symptom management plan, or if a new symptom has been identified.

3. Following medications and treatments, the assessment of symptom severity ”S”, on a scale of 0-10, would be the *minimum assessment* to be completed to monitor effectiveness in meeting patient's goal.

4. Symptom assessments should be documented so that all members of the care team will have a clear understanding of the symptom issue(s). Location of documentation to be determined at each care site.

5. To complete the Symptom Assessment Acronym Tool, begin by recording the Palliative Performance Scale (PPS%).

6. Record the etiology of the symptom and any physical findings and comments in the space provided.

7. Date and sign the assessment.

8. When efforts of the primary care providers do not relieve the symptom(s), a consultation to the Palliative Care Consultation Team (10-513-7009) should be considered.