



Patient's Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Postal Code: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_  
 PHN: \_\_\_\_\_  
 (or Addressograph or Stamp)

(FACILITY)

# Hospice Palliative Care Program EDMONTON SYMPTOM ASSESSMENT SYSTEM GRAPH

<b>Date</b>														
<b>Time</b>														

<b>Pain</b>	10															
0																

<b>Tiredness</b>	10															
0																

<b>Nausea</b>	10															
0																

<b>Depression</b>	10															
0																

<b>Anxiety</b>	10															
0																

<b>Drowsiness</b>	10															
0																

<b>Appetite</b>	10															
0																

<b>Wellbeing</b>	10															
0																

<b>Shortness Of Breath</b>	10															
0																

<b>Assessed By;</b>																
<b>Assessed By Code:</b>	P = Patient	C = Caregiver (initial)	A = Caregiver Assisted													
<b>PPS</b>																
<b>Cognition</b>																
<b>Cognition Code:</b>	N = Normal	I = Impaired	<b>Expected MMSE Score:</b>													