

PHASE-20 — rating scale for possible drug-related symptoms

Information about PHASE-20 is on the back of this form

Name	NHS number	N.I. number	Date		
Document completed: <input type="checkbox"/> Independently <input type="checkbox"/> With support of relativ/next of kin/P.O.A <input type="checkbox"/> With support of health professional Name:					
Tick the box next to the option that best describes the level of discomfort during the last two weeks. Please leave clarifying comments in the margin when necessary. <u>Circle</u> the words that best match the symptoms and cross-out those that do not match.					
	No problem	Minor problem	Moderate problem	Severe problem	Comments
1. Dizzy/unsteady/high risk of falls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Tired/exhausted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Poor sleep pattern/nightmares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Abdominal pain/chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Low mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Worried/anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. Irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9. Forgetful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13. Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14. Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
15. Palpitations (rapid/irregular heartbeat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
16. Swollen legs/ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17. Short of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18. Frequent urination/incontinent of urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19. Itching/rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20. Other symptoms, which you have experienced during the past two weeks, (for example pain), indicate which. -----					
<input type="checkbox"/> Minor problem <input type="checkbox"/> Moderate problem <input type="checkbox"/> Severe problem					

Additional comments:

User-instructions for PHASE-20

The purpose of PHASE-20 (PHArmacoTherapeutical Symptom Evaluation - 20 questions) scale is to assess if you experience symptoms that may be related to your medications. Your health practitioner greatly appreciates your help with this.

Tick the box that best describes the symptoms you have had over the **last two weeks**. Please use the comments box if you want to say something specific about a certain symptom.

Where more than one symptom is mentioned, for example dizzy/unsteady/high risk of falls, please circle the one that concerns you the most, or indicate that you are not affected by it by crossing it out.

Example:

If you feel very “unsteady” but not “dizzy”, write dizzy/unsteady/high risk of falls

For relatives who may need to assist the completion of this document

Note that your relative should make the rating of the symptoms independently and without influence, as much as possible. Your task is primarily to help read and ask about each of the symptoms and complete the form. Keep in mind that it only concerns the last two weeks.

If you are assessing the symptoms as the representative of the patient, this should be noted on the form as it is important for the health practitioner to know.

Mariann Hedström, Marianne Carlsson, Anna Ekman, Ulrika Gillespie, Christina Mörk & Kerstin Hulter Åsberg (2016): Development of the PHASE-Proxy scale for rating drug-related signs and symptoms in severe cognitive impairment, *Aging & Mental Health*, DOI: 10.1080/13607863.2016.1232364

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