Glasgow Antipsychotic Side-effect Scale (GASS)

Name:	DOB/ CHI:	Date:

Please list current medication and total daily doses below:

_____

_____

_____

This questionnaire is about how you have been recently. It is being used to determine if you are suffering from excessive side effects from your antipsychotic medication. Please place a tick in the column which best indicates the degree to which you have experienced the following side effects. Tick the **end** box if you found that the side effect distressed you.

	Over the **past week:**	**Never**	**Once**	**A few times**	**Every day**	**Tick this box if distressing**
1	I felt sleepy during the day					
2	I felt drugged or like a zombie					
3	I felt dizzy when I stood up and/or have fainted					
4	I have felt my heart beating irregularly or unusually fast					
5	My muscles have been tense or jerky					
6	My hands or arms have been shaky					
7	My legs have felt restless and/or I couldn't sit still					
8	I have been drooling					
9	My movements or walking have been slower than usual					
10	I have had, or people have noticed uncontrollable movements of my face or body					
11	My vision has been blurry					
12	My mouth has been dry					
13	I have had difficulty passing urine					
14	I have felt like I am going to be sick or have vomited					
15	I have wet the bed					
16	I have been very thirsty and/or passing urine frequently					
17	The areas around my nipples have been sore and swollen					
18	I have noticed fluid coming from my nipples					
19	I have had problems enjoying sex					
20	Men only: I have had problems getting an erection					

	Tick yes or no for the following questions about the **last three months**	*No*	*Yes*	*Tick if distressing*
21	Women only: I have noticed a change in my periods			
22	Men and women: I have been gaining weight			

NHS Lanarkshire

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Staff Information

1. Allow the patient to fill in the questionnaire themselves. Questions 1-20 relate to the previous week and questions 21-22 to the last three months.

2. Scoring
For questions 1-20

0 Points	"Never"
1 point	"Once"
2 points	"A few times"
3 points	"Everyday"

For questions 21 and 22;
award 3 points for a "yes" answer and 0 points for a "no".

Total for all questions =_____

3. For male and female patients a *total score* of:

0-21	absent/mild side-effects
22-42	moderate side-effects
43 and over	severe side-effects

4. Side effects covered by questions;

1-2	sedation and CNS side effects
3-4	cardiovascular side effects
5-10	extra-pyramidal side effects
11-13	anticholinergic side effects
14	gastro – intestinal side effects
15	genitourinary side effects
16	screening for diabetes mellitus
17-21	prolactinaemic side effects
22	weight gain

The column relating to the distress experienced with a particular side effect is not scored, but is intended to inform the clinician of the service user's views and condition.

Reference:
Waddell L, Taylor M. A new self-rating scale for detecting atypical or second generation antipsychotic side-effects. *J Psychopharm* 2008; 22(3): 238-43