

Testicular Torsion Pain Scale

There are no right or wrong answers. Mark the response that best describes you over the period stated, and answer every item.

Name: _____ **Date completed:** _____ dd / mm / yyyy

Date of birth: _____ dd / mm / yyyy **Record / MRN number:** _____

Answer each of the 10 items below. Choose the response that best describes the last two weeks unless you are told otherwise.

1. I understand what testicular torsion pain involves and why it has been recommended.

- ☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always

2. I am confident managing pain intensity, quality and location day to day.

- ☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always

3. Functional impact on daily activity has been discussed with me.

- ☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always

4. I know who to contact if something changes between appointments.

- ☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always

5. I am able to follow the advice I have been given about analgesic use and response.

- ☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always

6. I have enough information to make decisions about my care.

- ☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always

7. The symptoms I came in with have affected my daily activities.

- ☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always

8. I have found it difficult to keep up with escalation triggers and review points.

- ☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always

9. I have had support from family, friends or carers with this.

- ☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always

10. I am satisfied with the care I have received so far.

- ☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always

Anything else you would like the team to know

FOR OFFICE USE ONLY

Total score: _____

Interpretation: _____

Completed by: _____

Reviewed by / date: _____