Delirium Screening Tool

Suspect delirium if answer is yes on items 1 + 2 + (3 or 4) below.
First perform a Brief Interview of Mental Status, Staff Assessment, or brief cognitive test described on ***other side***.

1) Acute onset [ ] yes [ ] no [ ] uncertain*

Is there evidence of an acute change in mental status from the person's baseline?

*If uncertain, gather more information.

2) Inattention [ ] yes [ ] no [ ] uncertain*

Does the person have difficulty focusing attention (i.e., easily distracted or can't follow what is being said)?

*If uncertain, perform an Attention Screening Examination (ASE):

Directions: Say to the patient, **"I am going to read you a series of 10 letters. Whenever you hear the letter 'A,' indicate by squeezing my hand."** Read letters from the following letter list in a normal tone.

S A V E A H A A R T

Scoring: Errors are counted when patient fails to squeeze on the letter "A" and when the patient squeezes on any letter other than "A." Inattention is present if **3** or more errors are observed.

3) Disorganized thinking [ ] yes [ ] no [ ] uncertain*

Is the person's thinking disorganized or incoherent, as evidenced by rambling or irrelevant conversation, unclear or illogical flow of ideas, unpredictable switching from subject to subject?

*If uncertain, conduct the following question/command assessments:

Questions:

1. **Will a stone float on water?**
2. **Are there fish in the sea?**
3. **Does one pound weigh more than two pounds?**
4. **Can you use a hammer to pound a nail?**

Score: Patient earns 1 point for each correct answer out of 4.

Command:

Say to patient: **"Hold up this many fingers"** (Examiner holds two fingers in front of patient then puts them back down) **"Now do the same thing with the other hand"** (Not repeating the number of fingers).

Score: Patient earns 1 point if does entire command.

Disorganized thinking is present if combined scores are less than 4.

4) Altered Level of Consciousness [ ] yes [ ] no

Is the patient anything other than alert, calm and cooperative (at current time)? This may include **vigilant** (easily startled), **lethargic** (frequently dozed off when asked questions), or **stuperous** (very difficult to arouse and keep aroused), or **comatose** (could not be aroused).

Psychomotor retardation: (sluggishness, staring into space, staying in one position, moving slowly) may also count as a "yes" for this domain.