☐ **Southern NSW LHD**

☐ **Murrumbidgee LHD**

Facility_____ Date**:** ___/___/_____

ABBREVIATED MENTAL TEST (AMT) - AND DELIRIUM SCREENING FORM

SURNAME	UNIT NO/UAID
FIRST NAMES	

DOB	SEX	WARD	MO

Establish baseline cognition by completing Abbreviated Mental Test OR SMMSE for on all presentations 65 years + (45+ ATSI)

Time of test_____ Name of person completing test_____

QUESTION	**Score**
1. How old are you	
2. What is the time (nearest hour)	
Give the patient an address and ask them to repeat it at the end of the test e.g 42 Market St Queanbeyan	
3. What year is it?	
4. What is the name of this place	
5. Can the patient recognise two relevant persons (eg. Nurse/doctor or relative)	
6. What is your date of birth?	
7. When did the second world war start? (1939)	
8. Who is the current Prime Minister?	
9. Count down backwards from 20 to 1	
10 Can you remember the address I gave you?	
TOTAL SCORE	

- **If score 7 or less screen for delirium using the CAM (see next page)**
- **If score 8 or greater assess for delirium symptoms and risk**

If unable to complete AMT or SMMSE AND/OR regardless of score

- **Does the person present with or have a history of any recent/sudden change in behaviour, cognition, LOC or functional ability (including falls)?**

YES ☐ Screen for delirium with CAM (next page)

NO ☐ Does the person have any of the high level risk factors for delirium?

- ☐ Dementia or pre -existing cognitive impairment?
- ☐ Severe medical illness
- ☐ Dehydration
- ☐ Visual and or hearing impairment
- ☐ Depression
- ☐ Chronic Alcohol use > 2 drinks/day
- ☐ History of previous delirium

If yes to any of above insert delirium alert and prevention strategies into front of health record & refer to ASET/AARC/discharge planner

Ref: Clinical practice guidelines for the management of delirium in older people (AHMAC, 2006) updated 2011

ABBREVIATED MENTAL TEST (AMT) - & DELIRIUM SCREENING FORM

CONFUSION ASSESSMENT METHOD (CAM)

The CAM is a validated tool to be used in assisting with the differential diagnosis of Delirium. It should be used for any older person who appears to be disorientated / confused or who has any change in behaviour or LOC. It is important that the CAM is used in conjunction with a formal cognitive assessment (eg AMT/ SMMSE), good clinical and medical assessment, together with baseline cognition information from carers/family or the community or residential aged care service

Assessor Name: _____ Designation: _____

1. ACUTE ONSET AND FLUCTUATING COURSE

   a) Is there evidence of an acute change in mental status from the patients baselines? (*Obtained from carers/family)*

   b) Did the (abnormal) behaviour fluctuate during the day, that is tend to come and go or increase and decrease in severity? (*Including change in sleep/wake cycle*)

2. INATTENTION

   Did the patient have difficulty focusing attention, for example, being easily distracted or having difficulty keeping track of what was being said? *(use AMT/SMMSE)*

BOX 1

Yes_____

Yes_____

Yes_____

3. DISORGANISED THINKING

   Was the patient's thinking disorganised or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject? (*disorientation/confusion/hallucinations)*

4. ALTERED LEVEL OF CONSCIOUSNESS

   Overall, how would you rate the patient's level of Consciousness *(include fluctuations* ie *drowsy and hyper alert*)

   Alert (normal)

   ---Vigilant (hyperalert)
   ---Lethargic (drowsy, easily roused)
   ---Stupor (difficult to arouse)
   ---Coma (unrousable)

   Is the patient vigilant, lethargic, in a stupor or coma?

BOX 2

Yes_____

Yes_____

If all items in Box 1 are ticked AND at least one item in Box 2 is Ticked a diagnosis of Delirium is suggested.

IF YES TO SUGGESTED DELIRIUM

- Notify MO. **Refer to and follow delirium assessment and management procedure and pathway**
- Insert delirium alert and prevention/management strategies into MR
- Refer to ASET/AARC
- If severe behavioural disturbance – discuss with dementia/delirium CNC
- **Identify as falls risk**

IF NO TO SUGGESTED DELIRIUM

- Inset delirium risk alert and prevention strategies in MR
- If AMT <7 and no diagnosis of dementia complete SMMSE and or refer to ASET/AARC or MO for further assessment.
- If pt at high risk, repeat cognition screen using AMT/SMMSE/CAM if any change in cognition behaviour during admission
- **Identify as falls risk**