This form incorporates the Abbreviated Mental Test scores (AMTS), Delirium Risk Assessment Tool (DRAT) and Confusion Assessment Method (CAM).

**Abbreviated Mental Test Score (AMTS)**
Establish baseline cognition by completing the Abbreviated Mental Test OR MMSE for all presentations 65 years + (45+ ATSI). Repeat with any change in cognition behaviour or LOC. Score 1 for each correct answer.

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>Time</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How old are you?</td>
<td></td>
<td></td>
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<tr>
<td>2. What is the time (nearest hour)?</td>
<td></td>
<td></td>
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<tr>
<td>3. What year is it?</td>
<td></td>
<td></td>
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<tr>
<td>4. What is the name of this place?</td>
<td></td>
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<tr>
<td>5. Can the patient recognise two relevant persons? (eg. nurse / doctor or relative)</td>
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<td></td>
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<tr>
<td>6. What is your date of birth?</td>
<td></td>
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<tr>
<td>7. When did the second World War start? (1939)</td>
<td></td>
<td></td>
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<tr>
<td>8. Who is the current Prime Minister?</td>
<td></td>
<td></td>
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<tr>
<td>9. Count down backwards from 20 to 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Can you remember the address I gave you?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL SCORE**

Signature

- A score of 7 or less indicates cognitive impairment
- All patients require a Delirium Risk Assessment using DRAT (see over page)

Does the person have a history of any recent / sudden change in behaviour, cognition, loss of consciousness or functional abilities (including falls)?

☐ Yes - Please do CAM  ☐ No - Please do DRAT

Signature: ____________________________  Date: ____________________________
Print full name: __________________    Designation: ___________________
## Delirium Risk Assessment Tool (DRAT)

Assessment to be completed on admission, pre & post op, and when there is a change in behaviour

### Pre morbid RISK factors

- ≥ 70 yrs
- PLUS
  - Visual impairment (unable to read large print on newspaper with glasses)
  - Severe Illness (nurses' opinion including mental illness / depression)
  - Cognitive impairment AMTS < 7/10 or MMSE < 25/30 or past history of memory or cognitive deficit
  - Dehydration (scanty, concentrated urine, fever, thirst, dry mucous membranes or raised creatinine/urea)

If your patient is ≥ 70 yrs and has at least one of the above risk factors = **RISK of Delirium**

### Precipitating factors

- **WARNING**: these factors increase risk
  - Mechanical restraint
  - Malnutrition
  - 3 new medications added in 24hrs
  - IDC
  - Iatrogenic event (procedure, infection complications, falls etc)

### IF CHANGE IN BEHAVIOUR – RECOMMENDED INVESTIGATIONS

- CAM
- Medical review
- History (incl. family)
- Physical exam
- Medication review
- Bloods
- MSU

## 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/MMSE), good clinical and medical assessment, together with baseline cognition information from carers/family or the community or residential aged care service.

**DELIRIUM SCREENING TOOL**

### 1. Acute onset and fluctuating course

- No
- Yes

Uncertain, Specify: ______

Is there evidence of an acute change in mental status from the patient's baseline? If so, did the abnormal behaviour fluctuate during the day?

- e.g. tend to come and go or increase and decrease in severity

### 2. Inattention

- No
- Yes

Uncertain, Specify: ______

Did the patient have difficulty focussing attention during the interview?

- e.g. being easily distracted or having difficulty keeping track of what was being said

### 3. Disorganised thinking

- No
- Yes

Uncertain, Specify: ______

Was the patient's thinking disorganised or organised?

- e.g. rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from one subject to another

### 4. Altered level of consciousness

- No
- Yes

Uncertain, Specify: ______

Overall, how would you rate the patient's level of consciousness?

- Altered e.g. vigilant, lethargic, stupor, coma, uncertain

Delirium is present if features 1 and 2 AND either 3 or 4 are present

Medical symptoms: ☐ not present ☐ present

Date: / /

Medical Officer notified? ☐ Yes ☐ No

Signature: __________________________ Date: __________________________

Print full name: __________________________ Designation: __________________________

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