NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

DELIRIUM SCREEN FOR OLDER ADULTS

SMR060926

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.

QUESTION	**Time** **Date**	_____:_____ ___/___/_____	_____:_____ ___/___/_____	_____:_____ ___/___/_____	_____:_____ ___/___/_____
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 eg. 42 Market St					
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					
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: _____

NO WRITING

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

NH606735 240714

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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 Tick & add score

☐ **≥ 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

DELIRIUM SCREENING TOOL

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.

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

Delirium symptoms: ☐ not present ☐ present — Date: / /

Medical Officer notified? ☐ Yes ☐ No

Signature: _____ Date: _____

Print full name: _____ Designation: _____

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NO WRITING

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