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

DELIRIUM SCREEN FOR OLDER ADULTS

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

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

Abbreviated Mental Test Score (AMTS)

Health

Facility:

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 add		ask them to repeated 42 Market St	at it at the end of	the test	
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 imp All patients require a Delirium Risk Assessi		ng DRAT (see ov	er page)		
Does the person have a history of any recent / su abilities (including falls)?	udden cha	ange in behaviour	, cognition, loss c	of consciousness	or functional
Yes - Please do CAM No - Please	do DRAT				
Signature:			Date:		
Print full name:			_ Designation:		
	NO W	/RITING			Page 1 of 2

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				FAMILY NAME				MRN	MRN		
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Fac		eaith				D.O.B// M.O.					
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DELIRIUM SCREEN FOR OLDER ADULTS					LOCATION / WARD						
					COMP	LETE	ALL DETAILS	OR AFFIX I	PATIEN	T LABEL HERE	
		Assessment to be c						ool (DRAT when there is	•	in beha	aviour
	Pre morbid RISK factors Tick & add score							Pre	cipitatin	g fac	tors
	≥ 70 yr	s					WAF	RNING: these	factors in	crease	risk
	PLUS							Mechanical re	straint		
		impairment (unab	le to rea	ad large p	print on	newspaper	• "	vieci iai iicai Te	Straint		
$ \Box $:	with gla	sses) • illness (nurses' op depression)	oinion in	cluding n	mental		• 1	Malnutrition			
	Cognit	ive impairment A tory of memory or co	MTS < 7	7/10 or M	//MSE <	25/30 or	• 3	3 new medicat	ions addec	l in 24h	rs
	Dehyd	ration (scanty, cond membranes or raise	centrate	d urine, f		irst, dry	• 11	DC			
!		r patient is ≥ 70 yrs			,	of the	• 1:	atrogenic eve	nt (procedi	ıre infe	ction
	,	above ris	sk facto	rs =				complications,			
IF CH	IANGE	IN BEHAVIOUR			NDED II	NVESTIGA	TION	S			
CAM Medical History review (incl. family)						ledication Blood review					
(CAM		(inc	listory I. family	y) I	Physical exam	M	edication review	Bloo	ds	MSU
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	The Copersor is used	AM is a validated too to who appears to be d in conjunction with	I to be u	CONFU sed in as ated / cor cognitive from care	JSION A ssisting v nfused o e assess ers/family	ASSESSME with the different who has an imment (eg AM y or the comm	NT M ential of y char T/MMS nunity	ETHOD (CA diagnosis of da age in behavior SE), good clini	M) elirium. It shur or LOC. I cal and me aged care sence of nge in a from the eline? abnormal ctuate	nould be It is impo dical ass service.	e used for any older ortant that the CAM sessment, together and to come and go ease and decrease
	The C persor is used with ba	AM is a validated too n who appears to be d in conjunction with aseline cognition info	l to be udisorienta formal	CONFU sed in as ated / cor cognitive from care Yes	JSION Assisting volume of assess ers/family Uncerta	ASSESSME with the difference who has an ament (eg AM y or the community)	NT M ential of y char T/MM3 nunity	ETHOD (CA diagnosis of dage in behavior residential a ls there evide an acute cha mental status patient's base of the behaviour flu	elirium. It shur or LOC. I cal and me aged care sence of nge in a from the eline? abnormal ctuate y?	e.g. teror in sever	e used for any older ortant that the CAM sessment, together and to come and go ease and decrease
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