Delirium & Cognitive Impairment (4AT) Assessment

eFit electrontic Frailty Interprofessional Toolkit

Centre for Studies in Aging & Health — Creating, Applying & Sharing Knowledge — Providence Care

First Name Last Name	1950-01-31
First Name Last Name	2019-01-31

SCORING:

4 or above: possible delirium +/- cognitive impairment **1 - 3**: possible cognitive impairment

0: delirium or severe cognitive impairment unlikely (but delirium still possible if [4] information incomplete)

1 Alertness

This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.

0

Normal (fully alert, but not agitated, throughout assessment) = 0
Mild sleepiness for <10 seconds after waking, then normal = 0
Clearly abnormal = *4*

2 AMT4

Age, date of birth, place (name of the hospital or building), current year.

0

No mistakes = 0
1 mistake = 1
2 or more mistakes/untestable = 2

3 Attention

Ask the patient: “Please tell me the months of the year in backwards order, starting at December.” To assist initial understanding one prompt of “what is the month before December?” is permitted.
Months of the year backwards

0

Achieves 7 months or more correctly
Starts but scores <7 months / refuses to start
Untestable (cannot start because unwell, drowsy, inattentive)

4 Acute Change or Fluctuating Course

Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs.

0

No = 0
Yes = 1

4AT Score 0

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PLEASE NOTE: When saving this form rename the by **appending the patient's name** to the original file name.