Delirium & Cognitive Impairment (4AT) Assessment

The Delirium & Cognitive Impairment Assessment (4AT) is a screening instrument designed for rapid initial assessment of delirium and cognitive impairment.

Element	Details
Time to Administer	2 minutes
Type	Clinical Screening > eForm and Print Form versions
Setting	Any clinical setting upon first contact with the patient, and at other times when delirium is suspected.
Administration	Item 4 requires information from one or more source(s), e.g. your own knowledge of the patient, other staff who know the patient such as a ward nurse, a General Practitioner letter, case notes, or a caregiver. The tester should take into account communication difficulties (hearing impairment, dysphasia, lack of common language, etc.) when carrying out the test and interpreting the score. To help elicit any hallucinations and/or paranoid thoughts, ask the patient questions such as: • Are you concerned about anything going on here? • Do you feel frightened by anything or anyone? • Have you been seeing or hearing anything unusual?
Interpretation	**4 or above:** Possible delirium +/- cognitive impairment **1-3:** Possible cognitive impairment **0:** Delirium or severe cognitive impairment unlikely (but delirium still possible if information is incomplete)
Reference	MacLullich, A., Ryan, T., & Cash, H. (2011). RAPID CLINICAL TEST FOR DELIRIUM4AT: Rapid assessment test for delirium. Retrieved June 25, 2019, from http://www.the4at.com/