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Detecting delirium: Confusion Assessment Method (CAM) Shortened Version Worksheet

Name of client/resident: **Date of birth:**

Date: / / Time:

I. ACUTE ONSET AND FLUCTUATING COURSE

BOX 1

a) Is there evidence of an acute change in mental status from the patient's baseline? ○ No ○ Yes

b) Did the (abnormal) behaviour fluctuate during the day, that is tend to come and go or increase and decrease in severity? ○ No ○ Yes

II. INATTENTION

Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said? ○ No ○ Yes

III. DISORGANISED THINKING

BOX 2

Was the patient's thinking disorganised or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject? ○ No ○ Yes

IV. ALTERED LEVEL OF CONSCIOUSNESS

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

Alert (normal) ☐

BOX 3

Vigilant (hyperalert) ☐
Lethargic (drowsy, easily aroused) ☐
Stupor (difficult to arouse) ☐
Coma (unarousable) ☐

Do any checks appear in BOX 3? ○ No ○ Yes

If all items in BOX 1 are ticked and at least one item in BOX 2 is ticked a diagnosis of delirium is suggested.

Adapted with permission from: Inouye SK, vanDyck CH, Alessi CA, Balkin S, Siegal AP, Horwitz RI. Clarifying confusion: The Confusion Assessment Method. A new method for detection of delirium. Ann Intern Med. 1990; 113: 941-948.