EM Oldham

NHS
Oldham Care Organisation
Northern Care Alliance NHS Group
Version 2.0 August 2020

Delirium Screen : 4AT Assessment

For all patients age above 65 or with new onset confusion (any age) or with hip fracture.

Name:	Hosp Number:
DOB:	Date/time assessed:
Assessor:	

4AT assessment

[1] ALERTNESS

Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder.

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.

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."

Achieves 7 months or more correctly	0
Starts but scores <7 months / refuses to start	1
Untestable (cannot start because unwell, drowsy, inattentive)	2

[4] ACUTE CHANGE OR FLUCTUATING COURSE

Evidence of significant change or fluctuation in: alertness, cognition, other mental function.

No	0
Yes	4

Total :

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)

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Delirium Management Pathway