

DELIRIUM SYMPTOM SCREENING TOOL

Patient Name: _____

Assessor Name: _____

Start date: _____

End Date: _____

To be completed within 24 hours when a SUDDEN CHANGE in behaviour is noted which is not accounted for by pre-existing / established or evolving dementia.

<i>Indicators</i>	<i>Usual Behaviour Identify all those that apply</i>	<i>Noted Sudden Change in Behaviour (Describe changed behaviour)</i>	<i>Date / Time / Initial</i>
Sleep/Wake Cycle	Wake time _____ Sleep time _____ Rest time _____ Toileting times _____		
Activities of Daily Living	<input type="checkbox"/> Total Care <input type="checkbox"/> Needs assistance <input type="checkbox"/> Independent		
Communication	<input type="checkbox"/> Can understand others <input type="checkbox"/> Can make others understand self <input type="checkbox"/> Dentures fit and able to talk <input type="checkbox"/> Able to hear <input type="checkbox"/> Able to see		
Attention / Concentration	<input type="checkbox"/> Able to focus during conversation/ activity <input type="checkbox"/> Easily redirected <input type="checkbox"/> Able to complete a task		
Perceptual changes	<input type="checkbox"/> Interprets environment appropriately <input type="checkbox"/> Misperceptions <input type="checkbox"/> Hallucinations <input type="checkbox"/> Delusions <input type="checkbox"/> Paranoia <input type="checkbox"/> Other _____		
Memory	<input type="checkbox"/> Good <input type="checkbox"/> Fluctuates <input type="checkbox"/> Poor - short term <input type="checkbox"/> Poor - long term		
Psychomotor Activity	<input type="checkbox"/> Normal activity level <input type="checkbox"/> Hyper: agitated, restless, pacing <input type="checkbox"/> Hypo: lethargic, withdrawn, sluggish <input type="checkbox"/> Easily distracted <input type="checkbox"/> Demeanor: calm / irritable <input type="checkbox"/> History of falls		
Nutrition	Fluids <input type="checkbox"/> Adequate fluid intake <input type="checkbox"/> Resists fluids <input type="checkbox"/> Dehydrated Food <input type="checkbox"/> Adequate food intake <input type="checkbox"/> Resists eating <input type="checkbox"/> Poor nutritional state		

Adapted with permission: Earthy, A. (2002). Delirium CPG. Fraser Health Authority. Vancouver, BC.