Appendix #1 Intensive Care Delirium Screening Checklist Worksheet

Date					
Time					
1. Altered level of consciousness Choose **ONE** from A-E. Note: May need to reassess patient if recent administration of sedation therapy					
A. Exaggerated response to normal stimulation Riker/SAS = 5, 6, or 7 Score 1 point					
B. Normal wakefulness Riker/SAS = 4 Score 0 points					
C. Response to mild or moderate stimulation Riker/SAS = 3 Score 1 point (follows commands) **Score 0 if LOC related to recent sedation/analgesia**					
D. Response only to intense and repeated stimulation (e.g. loud voice and pain) SAS = 2 ****Stop assessment**		-	-	-	-
E. No response SAS = 1 ****Stop assessment**		-	-	-	-
2. Inattention Score 1 point for any of the following abnormalities: A. Difficulty in following commands OR B. Easily distracted by external stimuli OR C. Difficulty in shifting focus **Does the patient follow you with their eyes?**					
3. Disorientation Score 1 point for any one obvious abnormality: A. Mistake in either time, place or person **Does the patient recognize ICU caregivers who have cared for him/her and not recognize those that have not? What kind of place are you in? (list examples)**					
4. Hallucinations or Delusions Score 1 point for either : A. Equivocal evidence of hallucinations or a behavior due to hallucinations (Hallucination = perception of something that is not there with NO stimulus) OR B. Delusions or gross impairment of reality testing (Delusion = false belief that is fixed/unchanging) **Any hallucinations now or over past 24 hrs? Are you afraid of the people or things around you? [fear that is inappropriate to clinical situation]**					
5. Psychomotor Agitation or Retardation Score 1 point for either: A. Hyperactivity requiring the use of additional sedative drugs or restraints in order to control potential danger (e.g. pulling IV lines out or hitting staff) OR B. Hypoactive or clinically noticeable psychomotor slowing or retardation **Based on documentation and observation over shift by primary caregiver**					
6. Inappropriate Speech or Mood Score 1 point for either: A. Inappropriate, disorganized or incoherent speech OR B. Inappropriate mood related to events or situation **Is the patient apathetic to current clinical situation (ie. lack of emotion)?** **Any gross abnormalities in speech or mood? Is patient inappropriatelydemanding?**					
7. Sleep/Wake Cycle Disturbance Score 1 point for: A. Sleeping less than four hours at night OR B. Waking frequently at night (do not include wakefulness initiated by medical staff or loud environment) OR C. Sleep ≥ 4 hours during day **Based on primary caregiver assessment**					
8. **Symptom Fluctuation** Score 1 point for: fluctuation of any of the above items (ie. 1 – 7) over 24 hours (e.g. from one shift to another) **Based on primary caregiver assessment**					
TOTAL ICSDC SCORE (Add 1 – 8)					

A total ICSDC Score ≥ 4 has a 99% sensitivity correlation for a psychiatric diagnosis of delirium

Source: Bergeron N et al. Intensive Care Med 2001; 27:869-64 **Revised July 22 2005**