LANDSPÍTALI

# 4AT: Assessment test for delirium & cognitive impairment

| | | |
|---|---|---|
| **1) Alertness:** This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating. | 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."<br>To assist initial understanding one prompt of "what is the month before December?" is permitted. | 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 (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs | No | 0 |
| | Yes | 4 |
| **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) | **4AT score** | |

www.the4at.com

# STOP DELIRIUM

**AMMA** - Helstu áhættuþættir fyrir óráð: **A**ldraðir - **M**innisskertir - **M**jaðmarbrotnir - **A**lvarlega veikir

**P**ain

**I**nfection

**N**utrition

**C**onstipation

**H**ydration

**M**edication

**E**nvironment

Make sure any hearing aids and glasses are being worn and work well

Ábyrgð: ÞÞE/SAÞ/EÞG

LANDSPÍTALI https://island.is/s/landspitali/orad-er-orad