Centre intégré
de santé
et de services sociaux
de la Montérégie-Ouest
Québec

MOCLI60128

Dossier : _____

Nom, prénom : _____

Date de naissance : _____ ☐ F ☐ M
aaaa/mm/jj

NAM : _____ Exp. _____
aaaa/mm

Nom, prénom de la mère : _____

Installation : _____

ASSESSMENT TEST FOR DELIRIUM AND COGNITIVE IMPARMENT (4AT)

YYYY-MM	Score	DD hh:mm	DD hh:mm	DD hh:mm	DD hh:mm	DD hh:mm	DD hh:mm	DD hh:mm	DD hh:mm	DD hh:mm
[1] STATE OF CONSCIOUSNESS This includes patients who may be markedly drowsy (e.g. 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 less than 10 seconds after waking, then normal	**0**									
Clearly anormal	**4**									
[2] AMT4 Age, date of birth, place (name of hospital or building), current year.										
No mistakes	**0**									
1 mistake	**1**									
2 or more errors/untestable	**2**									
[3] ATTENTION Ask the patient: “Please tell me the months of the year in backwards order, starting at December?” To assist initial understanding, one prompt of “What is the month before December?" is permitted. Months of year backwards										
Achieves 7 months or more correctly	**0**									
Starts but scores less than 7 months or refuses to start	**1**									
Untestable (cannot start because unwell, drowsy or inattentive)	**2**									
[4] ACUTE CHANGE OR FLUCTUATING COURSE Evidence of significant change or fluctuation in: state of consciousness, cognition or other mental function (e.g. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24 hours.										
No	**0**									
Yes	**4**									
4 or more: possible delirium +/- cognitive impairment **1-3** : possible cognitive impairment **0** : delirium or severe cognitive impairment unlikely (but delirium still possible if information for [4] is incomplete)	**4AT Score**									
	INITIALS									

Version 1.2. Information and download: www.the4AT.com

Signature et titre	Initiales	Signature et titre	Initiales	Signature et titre	Initiales

Nom, prénom : #Dossier :

INSTRUCTIONS

The 4AT is a screening instrument designed for rapid initial assessment of delirium and cognitive impairment. A score of 4 or more suggests delirium but is not a diagnosis: more detailed assessment of mental status may be required to reach a diagnosis. A score of 0 does not definitively exclude delirium or cognitive impairment: more detailed testing may be required depending on the clinical context. Items 1-3 are rated solely on observation of the patient at the time of assessment. Item 4 requires information from one or more sources, e.g. your own knowledge of the patient, other staff who know the patient (e.g. ward nurses), attending physician

letter, case notes, caregivers. The tester should take account of communication difficulties (hearing impairment, dysphasia, lack of common language) when carrying out the test and interpreting the score.

State of consciousness: Altered state of consciousness is very likely to be delirium in general hospital settings. If the patient shows significant altered state of consciousness during the bedside assessment, score 4 for this item. Acute change or fluctuating course: Fluctuation can occur without delirium in some cases of dementia, but marked fluctuation usually indicates delirium. To help determine the presence of any hallucinations and/or paranoid thoughts, ask the patient questions such as: “Are you concerned about anything going on here?”, “Do you feel frightened by anything or anyone?”, “Have you been seeing or hearing anything unusual?”

Source : Voyer, P., Vilchesky, M., Richard, H., Pelletier, I., Ballard, S., Lundu, O. (2016). 4AT French version, Université Laval, Québec Canada