Confusion Assessment Method

Client Information				
Name: Date of birth:				
Gender: Date of Consultation:				
Address:				
Phone Number: Email Address:				
Instructions: Assess the following factors.				
Acute Onset				
1. Is there evidence of an acute change in mental status from the patient's baseline?				
YES NO UNCERTAIN NOT APPLICABLE				
Inattention (The questions listed under this topic are repeated for each topic where applicable.)				
2A. Did the patient have difficulty focusing attention (for example, being easily distractible or having difficulty keepir track of what was being said)?	וg			
Not present at any time during interview				
Present at some time during interview, but in mild form				
Present at some time during interview, in marked form				
Uncertain				
2B. (If present or abnormal) Did this behavior fluctuate during the interview (that is, tend to come and go or increase and decrease in severity)?	е			
YES NO UNCERTAIN NOT APPLICABLE				
2C. (If present or abnormal) Please describe this behavior.				
Disorganized Thinking				
3. Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable, switching from subject to subject?				
YES NO UNCERTAIN NOT APPLICABLE				

Adapted from Inouye et al., 1990)

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Altered Level of Consciousness

4. Overall, how would you rate this patient's level of consciousness?

A	Alert (normal)				
Vigilant (hyperalert, overly sensitive to environmental stimuli, startled very easily)					
<u></u> ι	Lethargic (drowsy, easily aroused)				
	Stupor (difficult to arouse)				
	Coma (unarousable	e) Uncertain			
Disorientation					
•		ny time during the interview, and bed, or misjudging the time	such as thinking that he or she was somewhere other e of day?		
YES	NO		NOT APPLICABLE		
Memory Impairn	nent				
	it demonstrate any r difficulty rememb		e interview, such as inability to remember events in		
YES	NO		NOT APPLICABLE		
Perceptual Distu	urbances				
	-	ce of perceptual disturbances thinking something was mov	s, such as hallucinations, illusions, or ing when it was not)?		
YES	NO		NOT APPLICABLE		
Psychomotor Ag	gitation				
-	-	-	sually increased level of motor activity, such as ng frequent, sudden changes in position?		
YES	NO		NOT APPLICABLE		
Psychomotor Re	etardation				
-	-		sually decreased level of motor activity, such as ng time, or moving very slowly?		
YES	NO		NOT APPLICABLE		
Altered Sleep-W	/ake Cycle				
9. Did the patien insomnia at ni		disturbance of the sleep-wa	ke cycle, such as excessive daytime sleepiness with		
YES	NO		NOT APPLICABLE		
Adapted from Inc	ouye et al., 1990)				
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SCORING:

For a diagnosis of delirium by CAM, the patient must display:

1. Presence of acute onset and fluctuating discourse

AND

2. Inattention

AND EITHER

3. Disorganized thinking

OR

4. Altered level of consciousness

Confusion Assessment Method (CAM) Diagnostic Algorithm

Feature 1: Acute Onset and Fluctuating Course

This feature is usually obtained from a family member or nurse and is shown by positive responses to the following questions: Is there evidence of an acute change in mental status from the patient's baseline? Did the (abnormal) behavior fluctuate during the day; that is, did it tend to come and go, or increase and decrease in severity?

Feature 2: Inattention

This feature is shown by a positive response to the following question: Did the patient have difficulty focusing attention; for example, being easily distractible, or having difficulty keeping track of what was being said?

Feature 3: Disorganized Thinking

This feature is shown by a positive response to the following question: Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

Feature 4: Altered Level of Consciousness

This feature is shown by any answer other than "alert" to the following question: Overall, how would you rate this patient's level of consciousness? (alert [normal], vigilant [hyperalert], lethargic [drowsy, easily aroused], stupor [difficult to arouse], or coma [unarousable])

Inouye SK, van Dyck CH, Alessi CA, Balkin S, Siegal AP, Horwitz RI. Clarifying confusion: the confusion assessment method. A new method for detection of delirium. Ann Intern Med. 1990;113(12):941-948.

