

## SHORT CONFUSION ASSESSMENT METHOD (SHORT CAM) WORKSHEET

*Note: This worksheet can be used as an alternative to the Short CAM Questionnaire. Testing of orientation and sustained attention is recommended prior to scoring, such as digit spans, days of week, or months of year backwards. This page can only be used to identify delirium cases. Please note it cannot be used to score severity using the CAM-S scoring system.*

EVALUATOR:

DATE:

### I. ACUTE ONSET AND FLUCTUATING COURSE

a) Is there evidence of an acute change in mental status from the patient's baseline?

No \_\_\_\_\_

b) Did the (abnormal) behavior fluctuate during the day, that is tend to come and go or increase and decrease in severity?

No \_\_\_\_\_

### II. INATTENTION

Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?

No \_\_\_\_\_

### III. DISORGANIZED THINKING

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?

No \_\_\_\_\_

### IV. ALTERED LEVEL OF CONSCIOUSNESS

Overall, how would you rate the patient's level of consciousness?

-- Alert (normal)

-- Vigilant (hyperalert)

-- Lethargic (drowsy, easily aroused)

-- Stupor (difficult to arouse)

-- Coma (unarousable)

Do any checks appear in the box above? ↑

No \_\_\_\_\_

**If Inattention and at least one other item in Box 1 are checked and at least one item in Box 2 is checked a diagnosis of delirium is suggested.**

**Confusion Assessment Method. Copyright 1988, 2003, Hospital Elder Life Program. Not to be reproduced without permission. Adapted from: Inouye SK, et al. Ann Intern Med.1990;113:941-8.**

**BOX 1**

Yes \_\_\_\_\_

Yes \_\_\_\_\_

Yes \_\_\_\_\_

**BOX 2**

Yes \_\_\_\_\_

Yes \_\_\_\_\_