The Confusion Assessment Method

Delirium should be suspected with the presence of Features 1 and 2 and either 3 or 4

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? Does the (abnormal) behaviour fluctuate during the day; that is, does it tend to come and go, or increase and decrease in severity?

YES

Feature 2: **Inattention**
This feature is shown by a positive response to the following question: Does the patient have difficulty focusing attention; for example, is the patient easily distractible, or having difficulty keeping track of what's being said?

YES

Feature 3:**Disorganized Thinking**
This feature is shown by a positive response to the following question: Is the patient's thinking disorganized or incoherent, as evidenced by rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

YES

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], stuporous [difficult to arouse], or comatose [unarousable])?

Lethargic

Inouye, S.K. (1990). Clarifying confusion; the confusion assessment method. A new method for detection of delirium. Ann Intern Med, 113 (12): 941-8.