As part of a quality improvement project, a DELIRIUM risk screening was performed on this patient.

**This patient is at ____HIGH/INTERMEDIATE/LOW_____ risk for delirium, with the following risk factors:

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        [] Fracture upon admission
        [] Age >=80            OR      [] Age>=65
        [] Infection upon admission
        [] BUN/Cr ratio > 18: _________
        [] Vision Deficit      OR      [] Hearing Deficit
        [] Acuity (ICU)

     Cognitive Difficulty
        [] _____ Clock-in-the-Box Score <=4
                 (range 0-8; 0=worst)
        [] Incorrect Days of Week Backwards
        [] Incorrect Months of Year Backwards
                 OR
        [] Cognitive difficulty/memory agent documented in H&P
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**Total # risk points upon screening:
(0-1.0 Low; 1.5-3 Intermediate; >=3.5 High)

**Monitor RASS for longitudinal monitoring of delirium:
_______ Modified RASS - consciousness (range -5 to +4; 0=best)

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*The Clock-in-the-Box (CIB) has been administered extensively at VABHS. Relative to primary care patients, a score of 4 or below suggests probable impairment. In other work, this correlated with a MMSE score of 24.

**Changes in RASS can be indicative of changes in consciousness characteristic of delirium. The Modified Richmond Agitation and Sedation Scale (RASS) is below:

RASS	Description
+4	Combative
+3	Very Agitated
+2	Slightly Agitated
+1	Restless
0	Alert and Calm
-1	Wakes Easily
-2	Wakes Slowly
-3	Difficult to Wake
-4	Can't Stay Awake
-5	Unarousable