PATIENT EVALUATION	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
Altered level of consciousness* (A-E)					
If A or B do not complete patient evaluation for the period					
Inattention					
Disorientation					
Hallucination - delusion – psychosis					
Psychomotor agitation or retardation					
Inappropriate speech or mood					
Sleep/wake cycle disturbance					
Symptom fluctuation					
TOTAL SCORE (0-8)					

Level of consciousness*		**Score**
	A: no response	none
	B: response to intense and repeated stimulation (loud voice and pain)	none
	C: response to mild or moderate stimulation	1
	D: normal wakefulness	0
	E: exaggerated response to normal stimulation	1

SCORING SYSTEM :
The scale is completed based on information collected from each entire 8-hour shift or from the previous 24 hours. Obvious manifestation of an item = 1 point. No manifestation of an item or no assessment possible = 0 point. The score of each item is entered in the corresponding empty box and is 0 or 1.

1. Altered level of consciousness:
A) No response or B) the need for vigorous stimulation in order to obtain any response signified a severe alteration in the level of consciousness precluding evaluation. If there is coma (A) or stupor (B) most of the time period then a dash (-) is entered and there is no further evaluation during that period.
C) Drowsiness or requirement of a mild to moderate stimulation for a response implies an altered level of consciousness and scores 1 point.
D) Wakefulness or sleeping state that could easily be aroused is considered normal and scores no point.
E) Hypervigilance is rated as an abnormal level of consciousness and scores 1 point.

2. Inattention: Difficulty in following a conversation or instructions. Easily distracted by external stimuli. Difficulty in shifting focuses. Any of these scores 1 point.

3. Disorientation: Any obvious mistake in time, place or person scores 1 point.

4. Hallucination, delusion or psychosis: The unequivocal clinical manifestation of hallucination or of behaviour probably due to hallucination (e.g. trying to catch a non-existent object) or delusion. Gross impairment in reality testing. Any of these scores 1 point.

5. Psychomotor agitation or retardation: Hyperactivity requiring the use of additional sedative drugs or restraints in order to control potential dangerousness (e.g. pulling out iv lines, hitting staff). Hypoactivity or clinically noticeable psychomotor slowing. Any of these scores 1 point.

6. Inappropriate speech or mood: Inappropriate, disorganised or incoherent speech. Inappropriate display of emotion related to events or situation. Any of these scores 1 point.

7. Sleep/wake cycle disturbance: Sleeping less than 4 hours or waking frequently at night (do not consider wakefulness initiated by medical staff or loud environment). Sleeping during most of the day. Any of these scores 1 point.

8. Symptom fluctuation: Fluctuation of the manifestation of any item or symptom over 24 hours (e.g. from one shift to another) scores 1 point.

Fig. 1 The Intensive Care Delirium Screening Checklist