TABLE 20 -- CONFUSION ASSESSMENT TOOL (CAM)
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CONFUSION ASSESSMENT METHOD (CAM)

Patients age ≥ 65 years are to be assessed with the CAM: at admission, Q12 hr. & PRN for mental status change.

Patients age ≤ 65 years may be assessed with the CAM for suspected delirium: at admission, Q12 hr. & PRN for mental status change.

Time: **hours**					
minutes					
1. Evidence of an acute change in mental status from patient's baseline. (Y=yes, N=no)	○ Y ○ N	○ Y ○ N	○ Y ○ N	○ Y ○ N	○ Y ○ N
2. Evidence of inattention: difficulty focusing, easily distracted, unable to follow topic. (Y=yes, N=no)	○ Y ○ N	○ Y ○ N	○ Y ○ N	○ Y ○ N	○ Y ○ N
3. Evidence of disorganized thinking: Rambling, irrelevant conversation, unpredictable subject switch. (Y=yes, N=no)	○ Y ○ N	○ Y ○ N	○ Y ○ N	○ Y ○ N	○ Y ○ N
4. What is the patient's level of consciousness? • Alert (A) • Vigilant (V) - hyperalert • Lethargic (L) - drowsy, easy to arouse • Stupor (S) - difficult to arouse • Coma (C) - unarousable	○ A=N ○ V=Y ○ L=Y ○ S=Y ○ C=Y	○ A=N ○ V=Y ○ L=Y ○ S=Y ○ C=Y	○ A=N ○ V=Y ○ L=Y ○ S=Y ○ C=Y	○ A=N ○ V=Y ○ L=Y ○ S=Y ○ C=Y	○ A=N ○ V=Y ○ L=Y ○ S=Y ○ C=Y
A=No All others=Yes (indicate which is present)	○ Y ○ N	○ Y ○ N	○ Y ○ N	○ Y ○ N	○ Y ○ N
SCORE: (+) or (-)					
RN Initials:					
Pt Care Provider Initials:					

Scoring: (-) CAM (delirium not present) = N for 1 or 2
(+) CAM (delirium present) = Y for 1 and 2 + Y for 3
Y for 1 and 2 + Y for 4
Y for 1 and 2 + Y for 3 and 4

If CAM is (+), implement Delirium Precautions and Delirium Management Nursing Interventions.