# Intensive Care Delirium Screening Checklist (ICDSC)

1. **Altered level of consciousness. Choose one from A to E**
   - **A. Exaggerated response to normal stimulation**
     - SAS = 5, 6, 7 or RASS = +1 to +4  (1 point)
   - **B. Normal wakefulness**
     - SAS = 4 or RASS = 0  (0 points)
   - **C. Response to mild or moderate stimulation (follows commands)**
     - SAS = 3 or RASS = −1 to −3  (1 point)
   - **D. Response only to intense and repeated stimulation (e.g., loud voice and pain)**
     - SAS = 2 or RASS = −4  Stop assessment*
   - **E. No response**
     - SAS = 1 or RASS = −5  Stop assessment*

2. **Inattention (1 point if any present)**
   - **A. Difficulty in following commands or**
   - **B. Easily distracted by external stimuli or**
   - **C. Difficulty in shifting focus**
   - *Does the patient follow you with their eyes?*

3. **Disorientation (1 point for any abnormality)**
   - **A. Mistake in either time, place, or person**
   - *Does the patient recognize ICU caregivers who have cared for him/her and not recognize those who have not? What kind of place are you in? (list examples)*

4. **Hallucinations or delusions (1 point for either)**
   - **A. Equivocal evidence of hallucinations or a behavior due to hallucinations (hallucination = perception of something that is not there with no stimulus) or**
   - **B. Delusions or gross impairment of reality testing (delusion = false belief that is fixed/unchanging)**
   - *Any hallucinations now or over past 24 hr? Are you afraid of the people or things around you? (fear that is inappropriate to the clinical situation)*

5. **Psychomotor agitation or retardation (1 point for either)**
   - **A. Hyperactivity requiring the use of additional sedative drugs or restraints in order to control potential danger (e.g., pulling IV catheters out or hitting staff) or**
   - **B. Hypoactive or clinically noticeable psychomotor slowing or retardation**
   - *Based on documentation and observation over shift by primary caregiver*

6. **Inappropriate speech or mood (1 point for either)**
   - **A. Inappropriate, disorganized, or incoherent speech or**
   - **B. Inappropriate mood related to events or situation**
   - *Is the patient apathetic to current clinical situation (i.e., lack of emotion)?*
   - *Any gross abnormalities in speech or mood? Is patient inappropriately demanding?*

7. **Sleep/wake cycle disturbance (1 point for any abnormality)**
   - **A. Sleeping < 4 hr at night or**
   - **B. Waking frequently at night (do not include wakefulness initiated by medical staff or loud environment) or**
   - **C. Sleep ≥ 4 hr during day**
   - *Based on primary caregiver assessment*

8. **Symptom fluctuation (1 point for any)**
   - Fluctuation of any of the above items (i.e., 1–7) over 24 hr (e.g., from one shift to another)
   - *Based on primary caregiver assessment*

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*Delirium assessment can not be completed in patients who are stuporous or comatose.
SAS = Riker Sedation-Agitation Scale, RASS = Richmond Agitation-Sedation Scale.