

FOR HEALTHCARE PROFESSIONALS

4AT scoring:

12 worked comic cases

These 12 comics show how the 4AT is scored in different clinical situations. Each comic is followed by a short explanation.

Professor Alasdair MacLulich

An optional workbook containing the comics and their explanations.

Before you start

It helps to be familiar with the main features of delirium before learning the scoring. Delirium develops over hours or days and affects attention, awareness, and other mental functions. It usually arises with acute illness, surgery, drug effects, or other physiological disturbance. The features often fluctuate. Delirium can occur in someone who already has dementia.

[Read the brief delirium care guide on the4AT.com](#)

[Read Introduction to delirium on Delirium Academy](#)

[Read the free 4AT Manual](#)

By the end, you should be able to

- Score all four items using the official rules.
- Distinguish brief sleepiness on waking from abnormal alertness.
- Distinguish an attempted or refused task from inability to start because of the clinical state.
- Use observations and records to establish recent change, including without a family informant.
- Interpret the item pattern and total in someone with or without dementia.
- Record and communicate the findings clearly.

You do not need a course or certificate to use the 4AT. This workbook is for practice with scoring; it does not assess clinical competence or cover recovery.

Using the comics

The 4AT combines observation, four orientation questions, a test of attention, and information about recent change. Read each comic, then look at the explanation on the next page. If you print the workbook double-sided, the comic and its explanation sit beside each other.

About the cases

- These example cases are set in 2026. In practice, use the actual assessment date and the patient's records.
- Some AMT4 bubbles collect four questions to save space. Ask them one at a time, without hints. Some answers are abbreviated or not shown; use the stated case findings.
- Cases 7 and 8 are a linked pair. They show the same resident at her usual baseline and then with a new change.

Before the assessment

Explain what you are going to do. Reduce background noise, check hearing aids and glasses, and give the person time to answer. Use an interpreter when needed. Keep the official form beside you while learning.

[Download the current official 4AT form](#)

What the total means

- 0:** Delirium or severe cognitive impairment unlikely.
- 1-3:** Possible cognitive impairment.
- 4 or more:** Possible delirium, with or without cognitive impairment.

A positive score identifies possible delirium for clinical assessment. A score below 4 does not exclude delirium when the history or observations remain concerning. The 4AT does not itself diagnose dementia. Record the item scores as well as the total.

Help with communication

For hearing loss, written questions may help. With aphasia, use the person's best available communication method and involve speech and language therapy where possible. If clinical impairment prevents a meaningful attempt despite support, score the cognitive items as untestable and record why. Aphasia alone does not make alertness abnormal.

If there is no shared language, use an interpreter and an appropriate 4AT translation. If this prevents testing and no interpreter is available, record the cognitive items as not administered. Items 1 and 4 may still be scored. Do not invent a complete total.

The examples concern older adults in wards, emergency care, and care homes. They do not cover critical care, immediate recovery from anaesthesia, or assessment of recovery from delirium.

How the 4AT is scored

The summary below explains the four items. Use the current official form when assessing a patient. The manual gives more detail if you need it.

1. ALERTNESS

- 0** Normal throughout, or mild sleepiness lasting under 10 seconds after waking, then normal.
- 4** Clearly abnormal, such as marked drowsiness, repeatedly drifting off, or clear agitation/hyperactivity.

2. AMT4

- 0** No mistakes in age, date of birth, place, and current year.
- 1** One mistake.
- 2** Two or more mistakes, or untestable.

Ask one question at a time. Accept unprompted self-correction. 'Hospital' is a reasonable place answer; the formal hospital name is not required.

3. ATTENTION: MONTHS BACKWARDS

- 0** At least seven months correctly backwards from December, reaching June.
- 1** Starts but gives fewer than seven correct months, or refuses to start.
- 2** Cannot start because unwell, drowsy, or inattentive.

One initial prompt is allowed: 'What is the month before December?' Allow thinking time and accept an unprompted self-correction. Stop after seven correct months, an uncorrected error, or when the person cannot continue. Slow, accurate answers count. Saying only 'December' is an attempt and scores 1.

4. ACUTE CHANGE OR FLUCTUATING COURSE

- 0** No evidence meeting this rule.
- 4** Significant change or fluctuation in alertness, cognition, or other mental function arose in the last two weeks and remains evident in the last 24 hours.

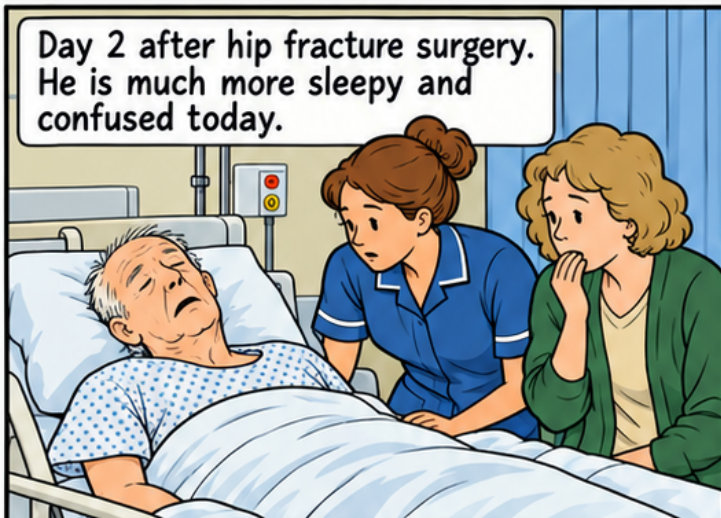
Use reliable staff, family, carer, patient, and record information. A qualifying overnight episode still counts when the person is clearer now. Family absence alone neither gives nor removes 4 points.

[Full scoring guidance: the4AT.com/userguide](https://the4AT.com/userguide)

4AT delirium tool - scoring example

Hip fracture ward - very drowsy patient

Day 2 after hip fracture surgery. He is much more sleepy and confused today.



1. ALERTNESS

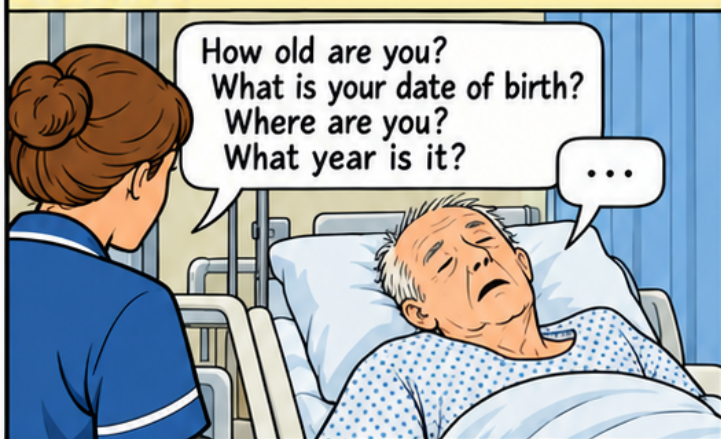
Mr Jones?
Can you hear me?



Clearly abnormal - score 4

2. AMT4

How old are you?
What is your date of birth?
Where are you?
What year is it?



Untestable - score 2

3. ATTENTION (MONTHS BACKWARDS)

Please tell me the months
of the year backwards,
starting from December.



Untestable - score 2

4. ACUTE CHANGE OR FLUCTUATING COURSE

This is a sudden
change from
yesterday.



Yes - score 4

TOTAL 4AT SCORE

Total 4AT score: 12/12

4 or above: possible delirium,
with or without cognitive impairment.

$$4 + 2 + 2 + 4 = 12$$



CASE 01

Marked drowsiness

Key point

The 4AT can be scored even when a patient cannot answer.

Mr Jones remains markedly drowsy and cannot attempt either cognitive test. Both cognitive items therefore score 2, for untestable. His daughter describes a sudden change, so item 4 scores 4. Being unable to attempt a test because of drowsiness is different from refusing it.

$$4 + 2 + 2 + 4 = 12$$

Total 12/12**Alertness: 4**

Marked drowsiness continues during assessment.

AMT4: 2

Cannot make a meaningful attempt.

Attention: 2

Cannot start because of drowsiness.

Acute change / fluctuation: 4

Daughter describes a sudden change since yesterday.

In practice

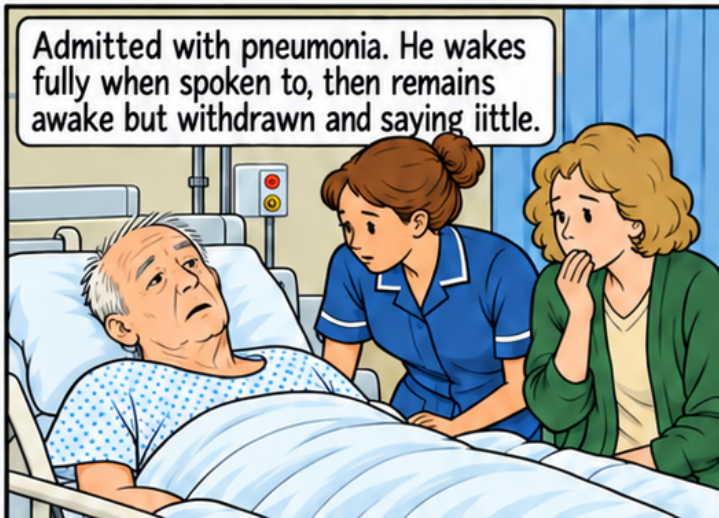
If the person cannot start because they are too drowsy or inattentive, use the untestable score. An explicit refusal to start months backwards scores 1.

Your notes

4AT delirium tool - scoring example

Medical ward - withdrawn with pneumonia

Admitted with pneumonia. He wakes fully when spoken to, then remains awake but withdrawn and saying little.



1. ALERTNESS

Mr Smith?
Can you hear me?

Yes... oh yes.

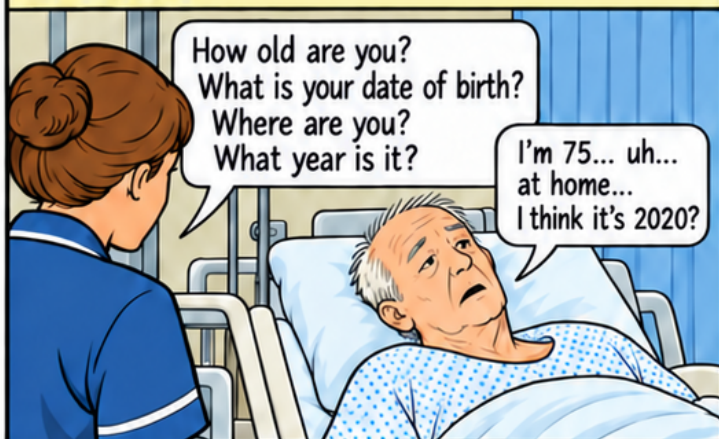


Sleepy at first, fully awake within seconds - score 0

2. AMT4

How old are you?
What is your date of birth?
Where are you?
What year is it?

I'm 75... uh...
at home...
I think it's 2020?



2 or more mistakes - score 2

3. ATTENTION (MONTHS BACKWARDS)

Please tell me the months
of the year backwards,
starting from December.

December...
er... no...
I can't do that.



Starts but fewer than 7 months - score 1

4. ACUTE CHANGE OR FLUCTUATING COURSE

He was much
clearer yesterday.



Yes - score 4

TOTAL 4AT SCORE

Total 4AT score: 7/12

4 or above: possible delirium,
with or without cognitive impairment.

$$0 + 2 + 1 + 4 = 7$$



CASE 02

Awake but withdrawn

Key point

Normal alertness does not exclude delirium.

Mr Smith wakes fully and remains awake during the assessment, so alertness scores 0. His errors on the AMT4, his difficulty with months backwards, and the change since yesterday give a total of 7. Being withdrawn and saying little do not, by themselves, make alertness abnormal.

$$0 + 2 + 1 + 4 = 7$$

Total 7/12

Alertness: 0

Becomes fully awake within seconds and stays awake.

AMT4: 2

Two or more errors.

Attention: 1

Starts, but gives fewer than seven correct months.

Acute change / fluctuation: 4

Daughter reports he was much clearer yesterday.

In practice

Being withdrawn does not itself tell you the alertness score. Look at whether the person stays awake and alert during the assessment.

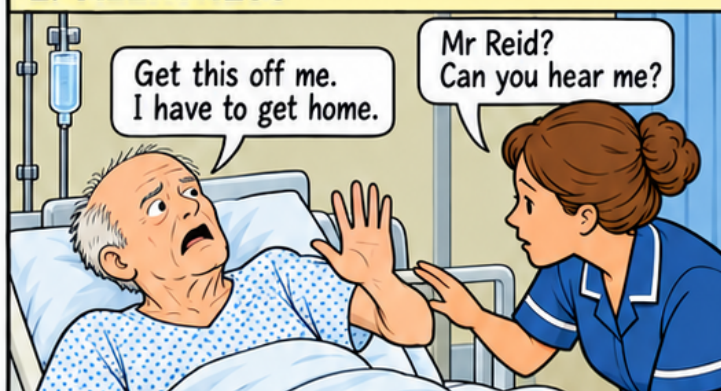
Your notes

4AT delirium tool - scoring example

Surgical ward - restless and agitated after surgery

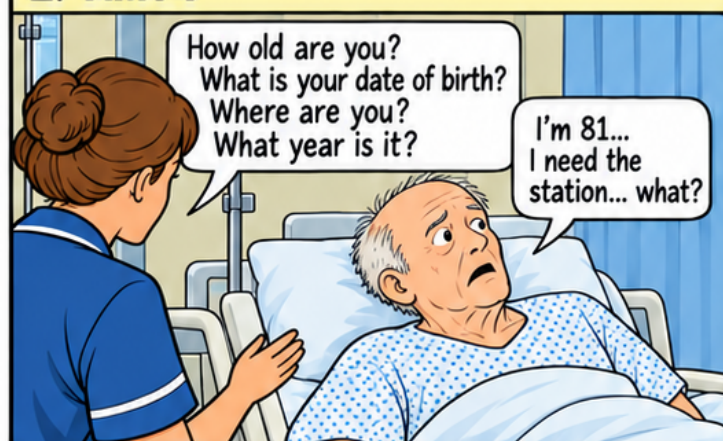


1. ALERTNESS



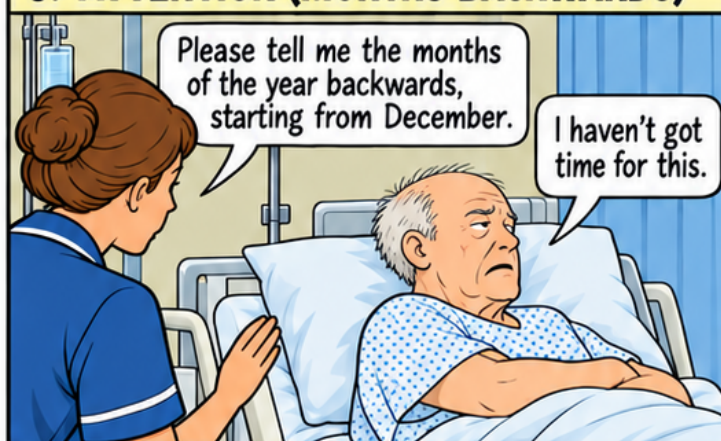
Clearly abnormal (agitated) - score 4

2. AMT4



2 or more mistakes - score 2

3. ATTENTION (MONTHS BACKWARDS)



Refuses to start - score 1

4. ACUTE CHANGE OR FLUCTUATING COURSE



Yes - score 4

TOTAL 4AT SCORE

Total 4AT score: 11/12

4 or above: possible delirium, with or without cognitive impairment.

$$4 + 2 + 1 + 4 = 11$$

Agitation counts as abnormal alertness.

CASE 03

Marked agitation

Key point

Marked agitation scores 4 for alertness.

Mr Reid is markedly agitated, makes errors on the AMT4, and has changed since yesterday. He refuses to attempt months backwards, which scores 1. Wanting to leave or feeling frustrated would not, by itself, establish abnormal alertness; his agitation in this case is clearly abnormal.

$$4 + 2 + 1 + 4 = 11$$

Total 11/12**Alertness: 4**

Clearly abnormal agitation during assessment.

AMT4: 2

Two or more errors.

Attention: 1

Explicitly refuses to start.

Acute change / fluctuation: 4

Son describes a new change from yesterday.

In practice

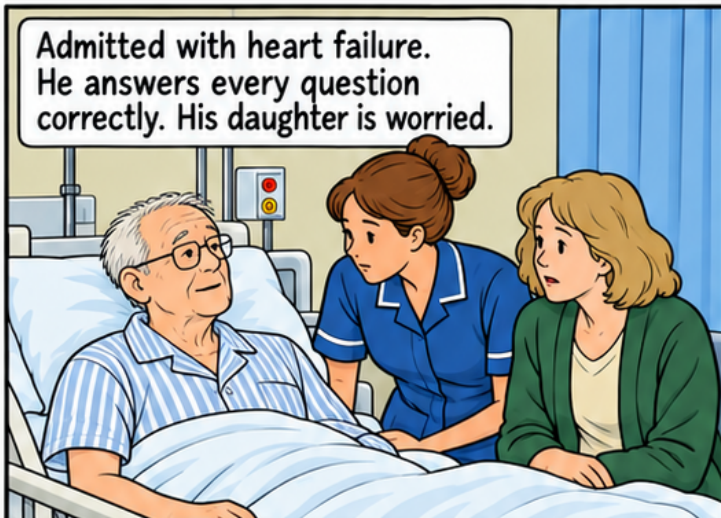
Score the clearly abnormal agitation shown in this case. Frustration or wanting to leave, on its own, does not justify 4 for alertness.

Your notes

4AT delirium tool - scoring example

Acute medical unit - normal testing, new hallucinations

Admitted with heart failure.
He answers every question
correctly. His daughter is worried.



1. ALERTNESS

Fine, thank you.
A bit tired.

Mr Brown?
How are you feeling?

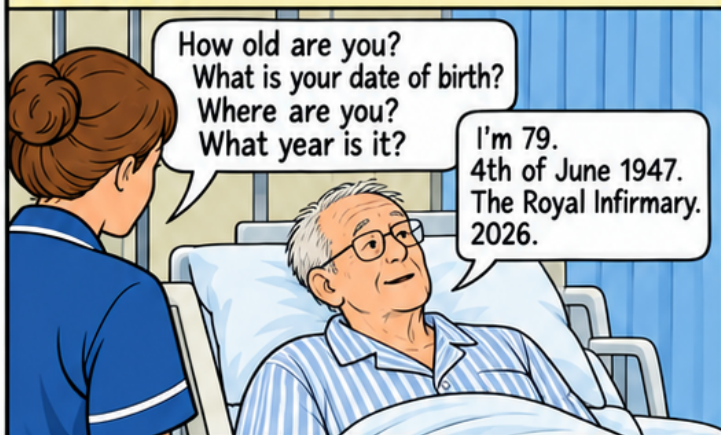


Normal - score 0

2. AMT4

How old are you?
What is your date of birth?
Where are you?
What year is it?

I'm 79.
4th of June 1947.
The Royal Infirmary.
2026.

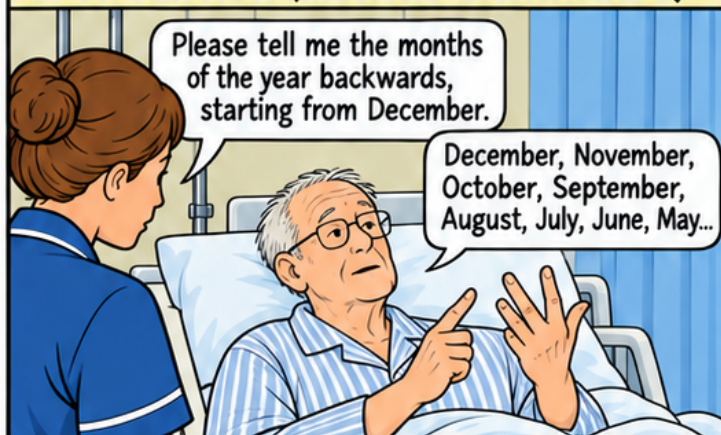


No mistakes - score 0

3. ATTENTION (MONTHS BACKWARDS)

Please tell me the months
of the year backwards,
starting from December.

December, November,
October, September,
August, July, June, May...



7 or more correct - score 0

4. ACUTE CHANGE OR FLUCTUATING COURSE

Last night he said there
were children in the garden.
There weren't. It started
two days ago.



Yes - score 4

TOTAL 4AT SCORE

Total 4AT score: 4/12

4 or above: possible delirium,
with or without cognitive impairment.

$$0 + 0 + 0 + 4 = 4$$

Item 4 alone gives a score of 4.
Assess further.



CASE 04

New hallucinations

Key point

Item 4 can make the test positive on its own.

Mr Brown answers the AMT4 questions and completes months backwards correctly. His daughter describes new hallucinations over the past two days, including last night. Item 4 therefore scores 4, although the other three items score 0.

$$0 + 0 + 0 + 4 = 4$$

Total 4/12**Alertness: 0**

Normal throughout this assessment.

AMT4: 0

All four answers are correct.

Attention: 0

At least seven correct months backwards.

Acute change / fluctuation: 4

New hallucinations began within two days and occurred last night.

In practice

Ask about recent changes even when the person answers correctly. New hallucinations can provide the evidence for item 4.

Your notes

4AT delirium tool - scoring example

Emergency department - refuses the months, wants to go home

Emergency department, after a fall at home. He is alert and wants to leave.



1. ALERTNESS

Yes. When can I go home?

Mr Khan?
Can you hear me?

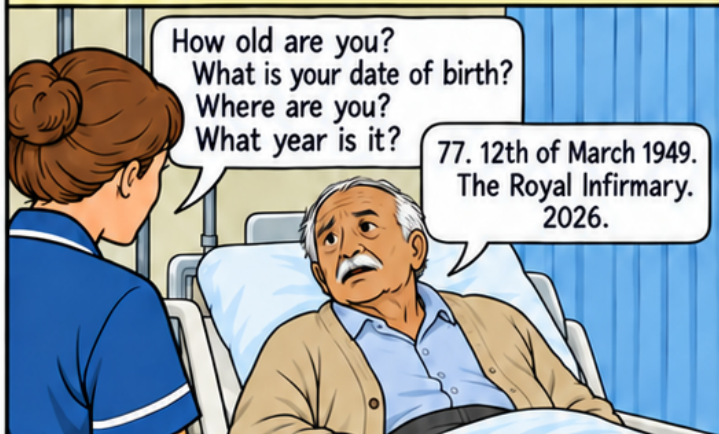


Normal - score 0

2. AMT4

How old are you?
What is your date of birth?
Where are you?
What year is it?

77. 12th of March 1949.
The Royal Infirmary.
2026.

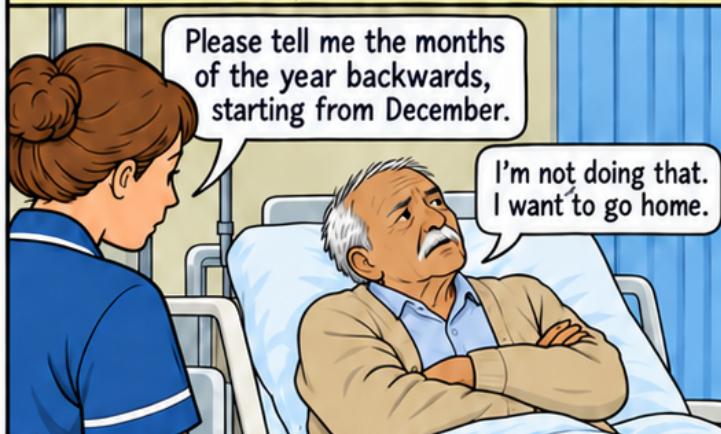


No mistakes - score 0

3. ATTENTION (MONTHS BACKWARDS)

Please tell me the months of the year backwards, starting from December.

I'm not doing that.
I want to go home.



Refuses to start - score 1

4. ACUTE CHANGE OR FLUCTUATING COURSE

He's been muddled since yesterday. He rang me three times in the night.



Yes - score 4

TOTAL 4AT SCORE

Total 4AT score: 5/12

4 or above: possible delirium, with or without cognitive impairment.

0 + 0 + 1 + 4 = 5

A refusal scores 1, not 0.



CASE 05

Refusing months backwards

Key point

Refusing to start months backwards scores 1.

Mr Khan is awake and answers the AMT4 questions correctly, but declines months backwards. This scores 1 for attention. His daughter describes a new change, so item 4 scores 4. His refusal does not tell us how well he would have performed the task.

$$0 + 0 + 1 + 4 = 5$$

Total 5/12

Alertness: 0

Alert and responsive.

AMT4: 0

All four answers are correct.

Attention: 1

Refuses to start, which scores 1.

Acute change / fluctuation: 4

New confusion and repeated calls overnight.

In practice

There is no need to guess how the person would have performed if they had agreed. Use the score for refusal.

Your notes

4AT delirium tool - scoring example

Care home resident - cognitive impairment but no acute change

Care home. Staff are concerned about her memory, but there has been no sudden change.



1. ALERTNESS

Yes, I'm fine.
It's nice to see you.

Mrs Adeyemi?
How are you today?

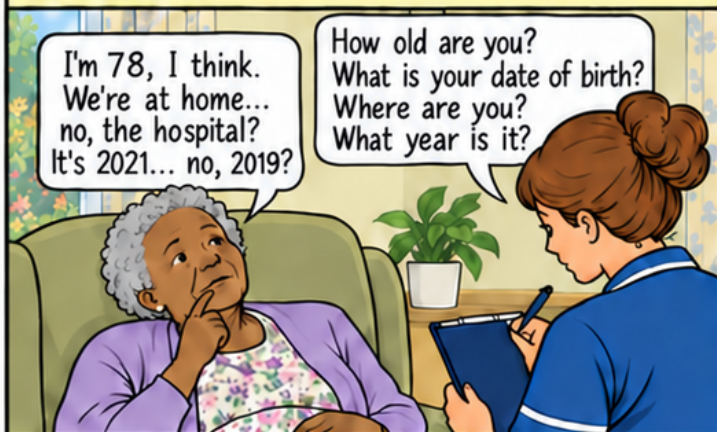


Normal - score 0

2. AMT4

I'm 78, I think.
We're at home...
no, the hospital?
It's 2021... no, 2019?

How old are you?
What is your date of birth?
Where are you?
What year is it?



2 or more mistakes - score 2

3. ATTENTION (MONTHS BACKWARDS)

Please tell me the months
of the year backwards,
starting from December.

December...
November...
October...
September...
August... July...



Starts but fewer than 7 months - score 1

4. ACUTE CHANGE OR FLUCTUATING COURSE

There hasn't been any
sudden change from
her usual self.



No - score 0

TOTAL 4AT SCORE

Total 4AT score: 3/12

1 to 3: possible cognitive impairment.

$$0 + 2 + 1 + 0 = 3$$

No acute change reported.
Consider a memory assessment.



CASE 06

No acute change

Key point

The carer reports no acute change.

Mrs Adeyemi makes errors on the AMT4 and gives six months in backwards order. Her carer reports no sudden change from her usual state. The total of 3 indicates possible cognitive impairment; it does not diagnose dementia.

$$0 + 2 + 1 + 0 = 3$$

Total 3/12**Alertness: 0**

Normal alertness.

AMT4: 2

Two or more errors.

Attention: 1

Six correct months: December to July.

Acute change / fluctuation: 0

No sudden change from usual reported.

In practice

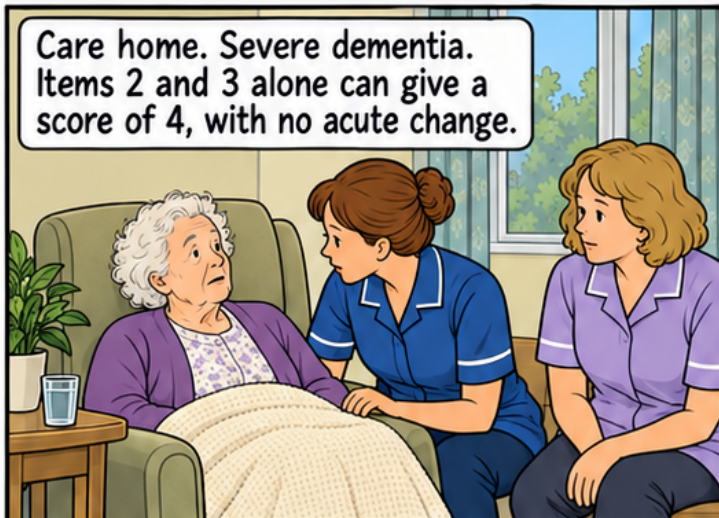
Write down the cognitive findings and the carer's account of the usual baseline. The 4AT result alone does not diagnose dementia.

Your notes

4AT delirium tool - scoring example

Severe dementia - a score of 4 with no acute change

Care home. Severe dementia.
Items 2 and 3 alone can give a
score of 4, with no acute change.

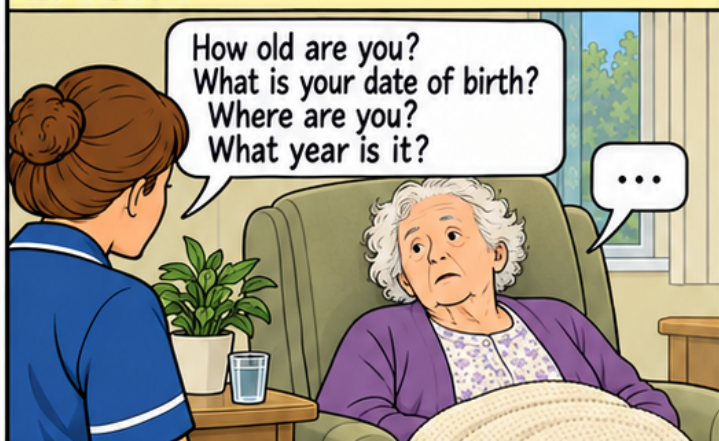


1. ALERTNESS



Normal - score 0

2. AMT4



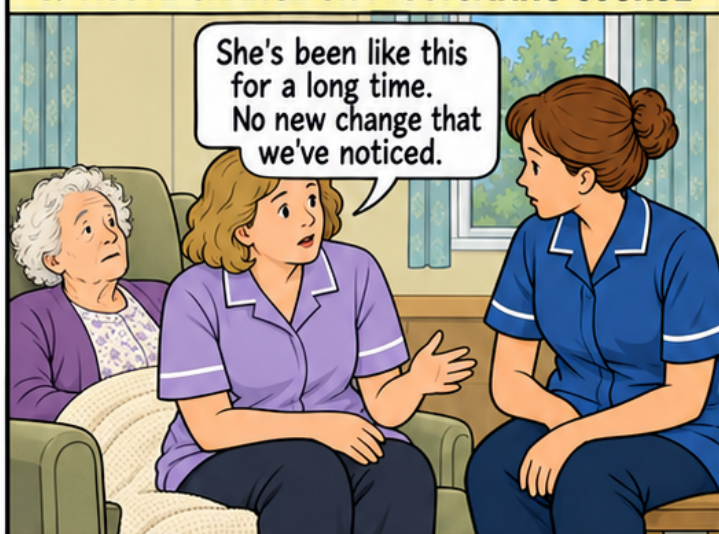
Untestable - score 2

3. ATTENTION (MONTHS BACKWARDS)



Untestable - score 2

4. ACUTE CHANGE OR FLUCTUATING COURSE



No - score 0

TOTAL 4AT SCORE

Total 4AT score: 4/12

4 or above: possible delirium,
with or without cognitive impairment.

$$0 + 2 + 2 + 0 = 4$$

Item 4 is negative. Check with a reliable
informant and reassess.



CASE 07

Severe dementia at baseline

Key point

Severe dementia can give a total of 4 without delirium.

Mrs Taylor has severe dementia. She is normally alert but cannot meaningfully attempt the AMT4 or months backwards. Each cognitive item scores 2, giving a total of 4/12.

Severe dementia can produce this result without delirium. Before attributing the score to her usual cognitive impairment, we need to be confident that her alertness is normal throughout the assessment and that a reliable informant confirms there has been no recent change or fluctuation. The informant should know her well enough to describe her usual mental state and how she has been recently. Being awake during a brief conversation is not enough on its own.

In this case, her carer confirms that this is her usual state. Together with normal alertness, that makes severe dementia without current delirium the more likely explanation. Record the score of 4 and the reasons for this interpretation, and continue to look for change. If the baseline is uncertain or alertness is abnormal, assess for possible delirium.

This situation was anticipated when the 4AT was designed. The aim was to maintain sensitivity, including in patients with delirium who are too drowsy or inattentive to attempt the cognitive tests. Giving 2 points for each untestable item allows these patients to receive a positive score and helps avoid missing delirium. The same scoring can also identify people whose difficulty comes from severe dementia. The clinician then uses alertness, the history and the rest of the assessment to interpret the result.

$$0 + 2 + 2 + 0 = 4$$

Total 4/12

Alertness: 0. Normal alertness throughout the assessment.

AMT4: 2. Untestable at her established baseline.

Attention: 2. Untestable at her established baseline.

Acute change / fluctuation: 0. A reliable carer confirms no recent change or fluctuation from her usual state.

In practice

Read case 8 next. It shows the same resident after a new change, with the first three item scores unchanged.

4AT delirium tool - scoring example

Severe dementia - the same resident, two weeks later

Mrs Taylor, two weeks later.
She is awake, but since this morning
she has not known her carers.



1. ALERTNESS

Mrs Taylor?
Can you hear me?

Yes?



Normal - score 0

2. AMT4

How old are you?
What is your date of birth?
Where are you?
What year is it?

...



Untestable - score 2

3. ATTENTION (MONTHS BACKWARDS)

Please tell me the months
of the year backwards,
starting from December.

...



Untestable - score 2

4. ACUTE CHANGE OR FLUCTUATING COURSE

This is new. Yesterday
she was chatting and
knew all of us.



Yes - score 4

TOTAL 4AT SCORE

Total 4AT score: 8/12

4 or above: possible delirium,
with or without cognitive impairment.

0 + 2 + 2 + 4 = 8

Same test results as page 7.
The sudden change makes the difference.



CASE 08

The same resident, a new change

Key point

The new change means item 4 scores 4.

Mrs Taylor's first three item scores are the same as in case 7. Since this morning, she has been unable to recognise familiar carers, so item 4 now scores 4. A person may still take part in familiar conversation even if they cannot manage the cognitive tests. "Two weeks later" refers to the time since the previous visit; the acute change began this morning.

$$0 + 2 + 2 + 4 = 8$$

Total 8/12**Alertness: 0**

Awake, without clearly abnormal alertness.

AMT4: 2

Untestable, as in case 7.

Attention: 2

Untestable, as in case 7.

Acute change / fluctuation: 4

New inability to recognise familiar carers since this morning.

In practice

Someone may manage familiar conversation but be unable to attempt the formal tasks. In this case, the new difficulty recognising carers is the change from usual.

Your notes

4AT delirium tool - scoring example

Admission unit - woken from sleep, one mistake

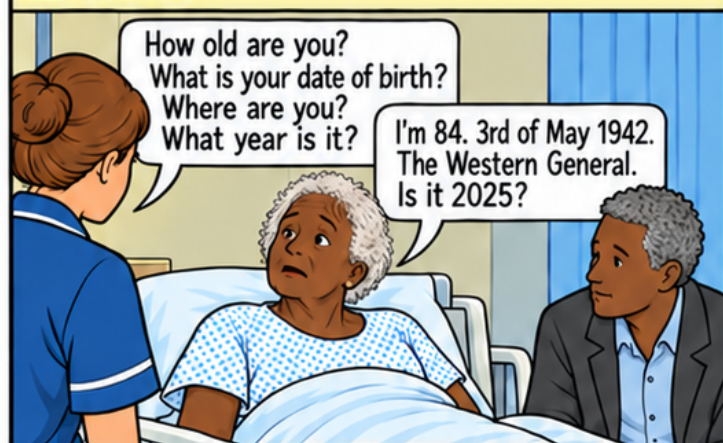


1. ALERTNESS



Sleepy for under 10 seconds after waking, then normal - score 0

2. AMT4



1 mistake - score 1

3. ATTENTION (MONTHS BACKWARDS)



7 or more correct - score 0

4. ACUTE CHANGE OR FLUCTUATING COURSE



No - score 0

TOTAL 4AT SCORE

Total 4AT score: 1/12

1 to 3: possible cognitive impairment.

$$0 + 1 + 0 + 0 = 1$$

Brief sleepiness on waking scores 0.
Consider further cognitive assessment.

CASE 09

Brief sleepiness on waking

Key point

Brief sleepiness on waking can be normal.

Mrs Murray becomes fully awake in under 10 seconds and remains awake, so alertness scores 0. She gives the year as 2025, but this case is set in 2026. This is one AMT4 error, giving a score of 1. The other items score 0.

$$0 + 1 + 0 + 0 = 1$$

Total 1/12**Alertness: 0**

Sleepiness lasts less than 10 seconds, then she is fully awake.

AMT4: 1

One error: she gives 2025 in this case, which is set in 2026.

Attention: 0

At least seven correct months.

Acute change / fluctuation: 0

Son reports her usual mental state.

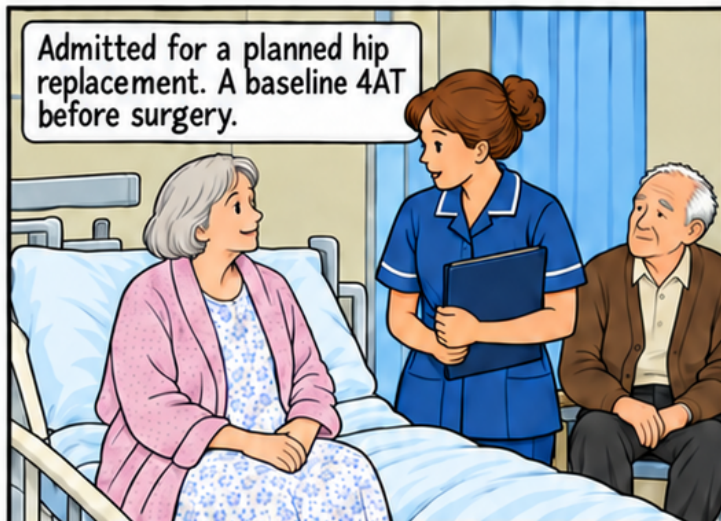
In practice

When you use the 4AT, check the answers against the real date. These teaching cases use 2026.

Your notes

4AT delirium tool - scoring example

Before a planned hip replacement - a normal baseline

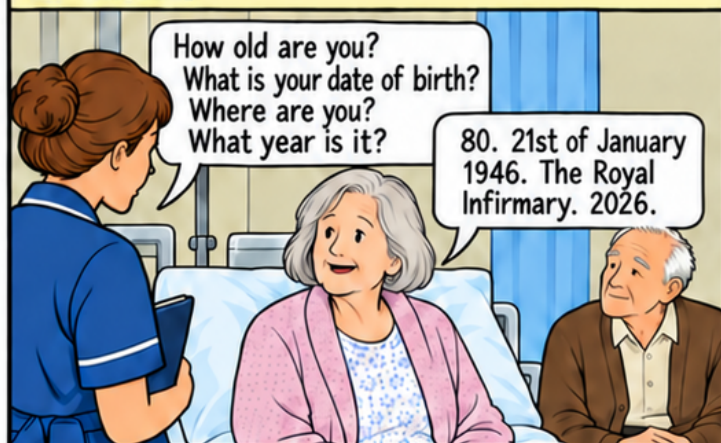


1. ALERTNESS



Normal - score 0

2. AMT4



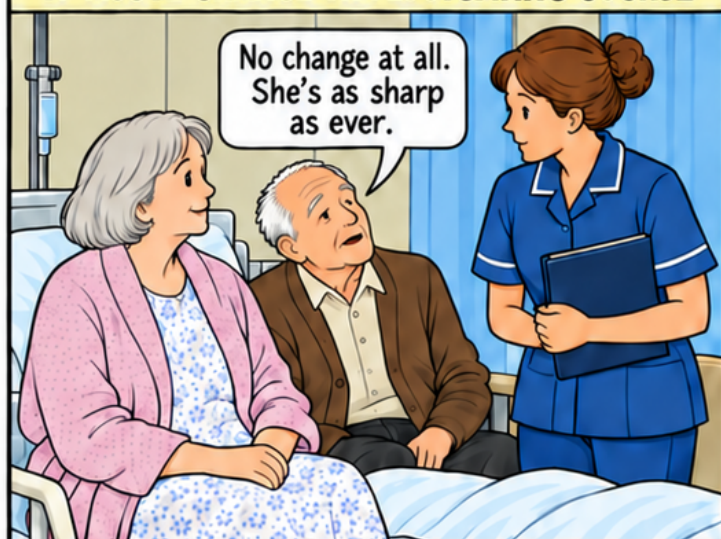
No mistakes - score 0

3. ATTENTION (MONTHS BACKWARDS)



7 or more correct - score 0

4. ACUTE CHANGE OR FLUCTUATING COURSE



No - score 0

TOTAL 4AT SCORE

Total 4AT score: 0/12

0: delirium or severe cognitive impairment unlikely, but delirium still possible if item 4 information is incomplete.

$$0 + 0 + 0 + 0 = 0$$

This is her baseline.
Repeat the 4AT after surgery.



CASE 10

A normal baseline

Key point

The recorded score provides a baseline for comparison.

Mrs Wilson is normally alert, completes both cognitive tests correctly, and has no evidence of recent change. Recording the date, four item scores and total allows staff to compare a later assessment with this one.

$$0 + 0 + 0 + 0 = 0$$

Total 0/12**Alertness: 0**

Normal alertness.

AMT4: 0

No errors.

Attention: 0

At least seven correct months.

Acute change / fluctuation: 0

No recent change or fluctuation.

In practice

Include the date, the four item scores, and the total in the record so others can compare with this assessment later.

Your notes

4AT delirium tool - scoring example

Overnight confusion and agitation, clearer this morning

Mr Hassan, 70, was admitted three days ago with a chest infection. His admission 4AT was 0. At 3am, he was restless and disorientated.



1. ALERTNESS

This morning

Good morning, Mr Hassan. How are you?

Much better, thank you.



Normal - score 0

2. AMT4

Questions asked one at a time. Age, date of birth and year correct.

Where are we just now?

At home.



1 mistake - score 1

3. ATTENTION (MONTHS BACKWARDS)

Please tell me the months of the year in backwards order, starting at December.

December, November, October, September, August, June.



Fewer than 7 correct - score 1

4. ACUTE CHANGE OR FLUCTUATING COURSE

At 3am he was restless and disorientated, wandering into the wrong bay. This was new.



Yes - score 4

TOTAL 4AT SCORE

Total 4AT score: 6/12

Possible delirium, with or without cognitive impairment.

$$0 + 1 + 1 + 4 = 6$$

The overnight change still counts this morning. Staff observations count towards item 4.



CASE 11

Clearer this morning

Key point

The night nurse's observations support item 4.

Mr Hassan is normally alert this morning. The night nurse describes new restlessness and disorientation at 3am, within the last 24 hours, so item 4 scores 4. His alertness score describes his state during the morning assessment, rather than his agitation overnight.

$$0 + 1 + 1 + 4 = 6$$

Total 6/12**Alertness: 0**

Normal alertness at the morning assessment.

AMT4: 1

One error.

Attention: 1

Fewer than seven correct months; July is skipped.

Acute change / fluctuation: 4

New overnight restlessness and disorientation, still within 24 hours.

In practice

Score alertness from this morning's assessment. The new episode overnight contributes to item 4, even though he is now clearer.

Your notes

4AT delirium tool - scoring example

No family informant available

Mr Williams, 85, was found on his kitchen floor. No family is reachable. His neighbour cannot describe his usual mental state.



1. ALERTNESS

Rouses to voice, mumbles, then drifts off again.



Clearly abnormal - score 4

2. AMT4

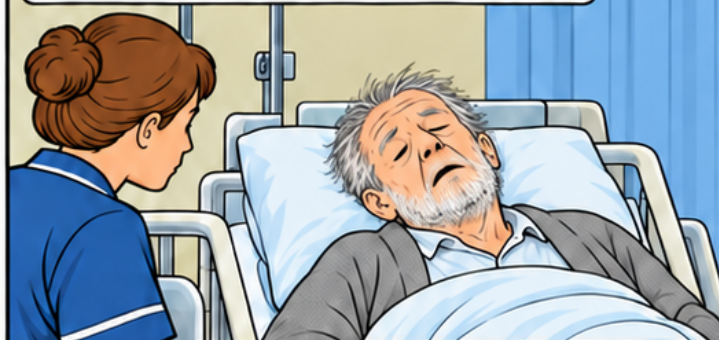
Too drowsy to make a meaningful attempt.



Untestable - score 2

3. ATTENTION (MONTHS BACKWARDS)

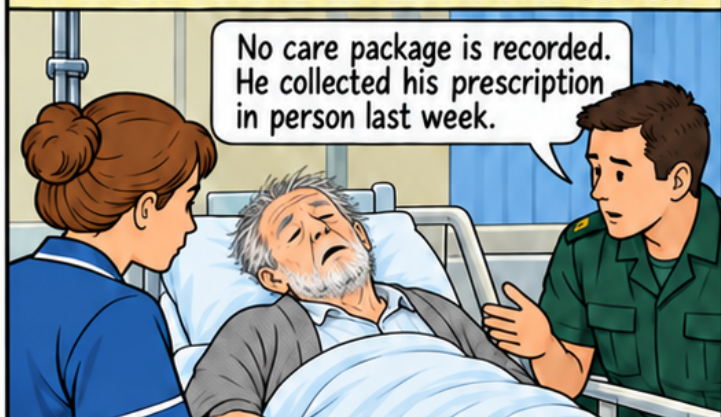
Cannot start because he is too drowsy.



Untestable - score 2

4. ACUTE CHANGE OR FLUCTUATING COURSE

No care package is recorded. He collected his prescription in person last week.



The available evidence supports an acute change in mental state.

Yes, by clinical judgement - score 4

TOTAL 4AT SCORE

Total 4AT score: 12/12

Possible delirium, with or without cognitive impairment.

4 + 2 + 2 + 4 = 12

A family informant is not required to score the 4AT.

Use the available evidence. Keep seeking a reliable history.



CASE 12

No family informant

Key point

Item 4 can be scored using the available clinical history.

Mr Williams is markedly drowsy and cannot attempt the cognitive tests. Given his recent activity and current marked drowsiness, it is reasonable to judge that this is an acute change, so item 4 scores 4. This judgement comes from the clinical history and his present state. The absence of family does not determine the score. His first three items already total 8.

$$4 + 2 + 2 + 4 = 12$$

Total 12/12**Alertness: 4**

Markedly drowsy, rouses briefly then drifts off.

AMT4: 2

Too drowsy to make a meaningful attempt.

Attention: 2

Cannot start because he is too drowsy.

Acute change / fluctuation: 4

Recent activity and present severe deterioration support acute change.

In practice

Use the available evidence and explain your judgement in the record. Keep seeking a reliable recent history.

Your notes

Recording and sharing the findings

Write down what you found, when you found it, and the information you used to judge recent change. This helps the next clinician understand the score.

An example from case 11

4AT at 09:00: alertness 0, AMT4 1, attention 1, acute change/fluctuation 4; total 6/12. At 03:00, the night nurse observed new restlessness, disorientation, and entry into another patient's bay. Admission 4AT 0. Possible delirium; findings handed to the clinical team.

What to record

- Date and time of the assessment.
- All four item scores and the total.
- Relevant observed behaviour and the patient's responses.
- The recent change, its timing, and the source of that information.
- Communication support, any limits, and relevant uncertainty.
- The action taken and who received the findings.

Observations from the whole team

Nurses, physiotherapists, occupational therapists, and speech and language therapists may notice changes during their work with a patient. Their observations can help establish an acute change. Record what happened, when it happened, and how it differs from the patient's usual state. Examples include new difficulty following familiar instructions during a transfer, using familiar objects, or maintaining a conversation. A fall, slow walking, or reduced intake alone does not establish an acute change in mental functioning for item 4.

Communicate possible delirium and follow the local clinical pathway. A marked reduction in consciousness or another immediate concern needs prompt attention; completing the score must not delay it.

For your next assessment

You might find it helpful to discuss one of the cases with a colleague. The online course also has short questions so you can check your understanding.

Further reading

The manual explains the scoring in more detail and includes further clinical cases. The links below take you to the manual and other official resources. Page numbers refer to the printed manual, not the PDF viewer.

The manual

MacLullich AMJ. *The 4AT Manual: a practical guide to delirium assessment*. First edition, version 1.0. Edinburgh: Delirium Support Press; 2026.

Useful sections: delirium, pp7-10; administration, pp11-17; interpretation, pp18-22; baseline and follow-up, pp25-26; clinical cases, pp36-57.

[the4AT.com/4at-manual](https://the4at.com/4at-manual)

Official 4AT resources

Current clinical form

<https://www.the4at.com/4at-download>

User guide and scoring rules

<https://www.the4at.com/userguide>

Worked cases

<https://www.the4at.com/4atcases>

Frequently asked questions

<https://www.the4at.com/4at-faq>

Cognitive impairment and dementia

<https://www.the4at.com/4at-cognitive-assessment-dementia>

Brief delirium care guide

<https://www.the4at.com/deliriumguide>

Delirium Academy

If you would like a fuller introduction, read **Introduction to delirium**. The **Persistent delirium** module covers ongoing symptoms and recovery, which are outside this scoring course.

deliriumacademy.com/introduction-to-delirium/

deliriumacademy.com/persistent-delirium/

Prepared by Professor Alasdair MacLullich. Educational draft for author review, 11 September 2026.