4AT scoring: quick print guide

This short guide summarises the scoring rules and the points illustrated by the 12 cases. You can print it to use alongside the course. Use the **official 4AT form** when assessing patients.

Before you start

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.

Short introduction to delirium: the4AT.com/deliriumguide

Current form: the4AT.com/4at-download

Free manual: the4AT.com/4at-manual

Item	Score	Rule
1. Alertness	0	Normal throughout assessment, or mild sleepiness for **less than 10 seconds** after waking, then normal.
	4	Clearly abnormal, such as marked drowsiness or clear agitation/hyperactivity.
2. AMT4	0 / 1 / 2	No mistakes = 0. One mistake = 1. Two or more mistakes, or untestable = 2.
3. Attention	0	At least seven months correctly backwards from December, reaching June.
	1	Starts but achieves fewer than seven correct months, or refuses to start.
	2	Cannot start because unwell, drowsy, or inattentive.
4. Acute change or fluctuating course	0 / 4	No = 0. Yes = 4: significant change or fluctuation in alertness, cognition, or other mental function arising in the last two weeks and still evident in the last 24 hours.

What the scores mean

0: delirium or severe cognitive impairment unlikely.
1-3: possible cognitive impairment.
4-12: possible delirium, with or without cognitive impairment.

A positive result indicates possible delirium for clinical assessment. If the history or your observations remain concerning, a low score does not rule out delirium. The 4AT does not diagnose dementia.

How to do the assessment

Helping the person answer

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. Not sharing a language is not evidence of cognitive impairment.

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 they cannot make 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.

AMT4: four orientation questions

Ask **age, date of birth, place, and current year**, one at a time without hints. A reasonable identification of the place, such as "hospital", is sufficient. Accept an unprompted self-correction.

Months backwards

Ask for the months backwards from December. One initial prompt is allowed: "What is the month before December?" Seven correct months, ending at June, are enough. Allow thinking time and an unprompted self-correction. **Stop after seven correct months, an uncorrected error, or when the patient cannot continue.** Slow, accurate answers count.

Saying only "December" is still a start. A start followed by failure, or an explicit refusal, scores 1. Being unable to start because of the person's clinical state scores 2.

Recent change or fluctuation

For item 4, look for acute change **or** fluctuation. Both are not required. The change must have arisen in the last two weeks and still be evident within the last 24 hours.

Use your own knowledge, staff observations, carers, family, records, and other reliable sources. A family informant is not required. When the available evidence supports a clear acute deterioration, clinical judgement can establish the change. If you are unsure, record what is missing and try to obtain more information. Family absence does not automatically give a score of 0 or 4.

Full administration guidance: the4AT.com/userguide

The twelve cases

Scores are in this order: **alertness / AMT4 / attention / acute change**. The total is out of 12. These example cases are set in **2026**; use the real assessment date in practice.

No.	Case and key point	Item scores	Total
01	**Marked drowsiness** The 4AT can be scored even when a patient cannot answer.	4 / 2 / 2 / 4	12
02	**Awake but withdrawn** Normal alertness does not exclude delirium.	0 / 2 / 1 / 4	7
03	**Marked agitation** Marked agitation scores 4 for alertness.	4 / 2 / 1 / 4	11
04	**New hallucinations** Item 4 can make the test positive on its own.	0 / 0 / 0 / 4	4
05	**Refusing months backwards** Refusing to start months backwards scores 1.	0 / 0 / 1 / 4	5
06	**No acute change** The carer reports no acute change.	0 / 2 / 1 / 0	3
07	**Severe dementia at baseline** With normal alertness throughout and a reliable carer confirming no change, severe dementia can make both cognitive items untestable and give a total of 4.	0 / 2 / 2 / 0	4
08	**The same resident, a new change** The new change means item 4 scores 4.	0 / 2 / 2 / 4	8
09	**Brief sleepiness on waking** Brief sleepiness on waking can be normal.	0 / 1 / 0 / 0	1
10	**A normal baseline** The recorded score provides a baseline for comparison.	0 / 0 / 0 / 0	0
11	**Clearer this morning** The night nurse’s observations support item 4.	0 / 1 / 1 / 4	6
12	**No family informant** Item 4 can be scored using the available clinical history.	4 / 2 / 2 / 4	12

Recording the findings

What to record

Record the date and time, four item scores, total, relevant observations, and who supplied the recent history. Note communication support, any limits, and relevant uncertainty. Communicate possible delirium according to your role and local pathway.

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 and disorientation. Admission 4AT 0. Possible delirium; findings handed to the clinical team.

Observations from other staff

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.

Marked reduction in consciousness or another immediate clinical concern needs prompt attention. Completing the scoring must not delay it.

Further reading

Current clinical form: the4at.com/4at-download

User guide: the4at.com/userguide

The 4AT Manual: the4at.com/4at-manual

Delirium care guide: the4at.com/deliriumguide

Introduction to delirium: deliriumacademy.com/introduction-to-delirium/

Persistent delirium: deliriumacademy.com/persistent-delirium/

Manual source: MacLullich AMJ. *The 4AT Manual: a practical guide to delirium assessment.* First edition, version 1.0 (2026). Administration and scoring, printed pp11-17; interpretation, pp18-22; clinical cases, pp36-57. Comics 11 and 12 draw on manual cases 8 (p41) and 23 (p50).

This introductory course focuses on administration and scoring in older adults in wards, emergency care, and care homes. It does not teach critical-care assessment, immediate recovery from anaesthesia, or serial assessment of delirium recovery. The link above has more information about recovery.

You do not need a course or certificate to use the 4AT. The guide is a reminder of the scoring, to use alongside the official form.