Memorial Delirium Assessment Scale (MDAS) ©1996

INSTRUCTIONS: Rate the severity of the following symptoms of delirium based on current interaction with subject or assessment of his/her behavior or experience over past several hours (as indicated in each item.)

ITEM 1-REDUCED LEVEL OF CONSCIOUSNESS (AWARENESS): Rate the patient's current awareness of and interaction with the environment (interviewer, other people/objects in the room; for example, ask patients to describe their surroundings).

- ☐ 0: none (patient spontaneously fully aware of environment and interacts appropriately)
- ☐ 1: mild (patient is unaware of some elements in the environment, or not spontaneously interacting appropriately with the interviewer; becomes fully aware and appropriately interactive when prodded strongly; interview is prolonged but not seriously disrupted)
- ☐ 2: moderate (patient is unaware of some or all elements in the environment, or not spontaneously interacting with the interviewer; becomes incompletely aware and inappropriately interactive when prodded strongly; interview is prolonged but not seriously disrupted)
- ☐ 3: severe (patient is unaware of all elements in the environment with no spontaneous interaction or awareness of the interviewer, so that the interview is difficult-to-impossible, even with maximal prodding)

ITEM 2-DISORIENTATION: Rate current state by asking the following 10 orientation items: date, month, day, year, season, floor, name of hospital, city, state, and country.

- ☐ 0: none (patient knows 9-10 items)
- ☐ 1: mild (patient knows 7-8 items)
- ☐ 2: moderate (patient knows 5-6 items)
- ☐ 3: severe (patient knows no more than 4 items)

ITEM 3-SHORT-TERM MEMORY IMPAIRMENT: Rate current state by using repetition and delayed recall of 3 words [patient must immediately repeat and recall words 5 min later after an intervening task. Use alternate sets of 3 words for successive evaluations (for example, apple, table, tomorrow, sky, cigar, justice)].

- ☐ 0: none (all 3 words repeated and recalled)
- ☐ 1: mild (all 3 repeated, patient fails to recall 1)
- ☐ 2: moderate (all 3 repeated, patient fails to recall 2-3)
- ☐ 3: severe (patient fails to repeat 1 or more words)

ITEM 4-IMPAIRED DIGIT SPAN: Rate current performance by asking subjects to repeat first 3, 4, then 5 digits forward and then 3, then 4 backwards; continue to the next step only if patient succeeds at the previous one.

- ☐ 0: none (patient can do at least 5 numbers forward and 4 backward)
- ☐ 1: mild (patient can do at least 5 numbers forward, 3 backward)
- ☐ 2: moderate (patient can do 4-5 numbers forward, cannot do 3 backward)
- ☐ 3: severe (patient can do no more than 3 numbers forward)

Breitbart W et al. The Memorial Delirium Assessment Scale. J Pain Symptom Manage. 1997 Mar;13(3):128-37.

ITEM 5-REDUCED ABILITY TO MAINTAIN AND SHIFT ATTENTION: As indicated during the interview by questions needing to be rephrased and/or repeated because patient's attention wanders, patient loses track, patient is distracted by outside stimuli or over-absorbed in a task.

- ☐ 0: none (none of the above; patient maintains and shifts attention normally)
- ☐ 1: mild (above attentional problems occur once or twice without prolonging the interview)
- ☐ 2: moderate (above attentional problems occur often, prolonging the interview without seriously disrupting it)
- ☐ 3: severe (above attentional problems occur constantly, disrupting and making the interview difficult-to-impossible)

ITEM 6-DISORGANIZED THINKING: As indicated during the interview by rambling, irrelevant, or incoherent speech, or by tangential, circumstantial, or faulty reasoning. Ask patient a somewhat complex question (for example, "Describe your current medical condition.").

- ☐ 0: none (patient's speech is coherent and goal-directed)
- ☐ 1: mild (patient's speech is slightly difficult to follow; responses to questions are slightly off target but not so much as to prolong the interview)
- ☐ 2: moderate (disorganized thoughts or speech are clearly present, such that interview is prolonged but not disrupted)
- ☐ 3: severe (examination is very difficult or impossible due to disorganized thinking or speech)

ITEM 7-PERCEPTUAL DISTURBANCE: Misperceptions, illusions, hallucinations inferred from inappropriate behavior during the interview or admitted by subject, as well as those elicited from nurse/family/chart accounts of the past several hours or of the time since last examination.

- ☐ 0: none (no misperceptions, illusions, or hallucinations)
- ☐ 1: mild (misperceptions or illusions related to sleep, fleeting hallucinations on 1-2 occasions without inappropriate behavior)
- ☐ 2: moderate (hallucinations or frequent illusions on several occasions with minimal inappropriate behavior that does not disrupt the interview)
- ☐ 3: severe (frequent or intense illusions or hallucinations with persistent inappropriate behavior that disrupts the interview or interferes with medical care)

ITEM 8-DELUSIONS: Rate delusions inferred from inappropriate behavior during the interview or admitted by the patient, as well as delusions elicited from nurse/family/chart accounts of the past several hours or of the time since the previous examination.

- ☐ 0: none (no evidence of misinterpretations or delusions)
- ☐ 1: mild (misinterpretations or suspiciousness without clear delusional ideas or inappropriate behavior)
- ☐ 2: moderate (delusions admitted by the patient or evidenced by his/her behavior that do not or only marginally disrupt the interview or interfere with medical care)
- ☐ 3: severe (persistent and/or intense delusions resulting in inappropriate behavior, disrupting the interview or seriously interfering with medical care)

ITEM 9-DECREASED OR INCREASED PSYCHOMOTOR ACTIVITY: Rate activity over past several hours, as well as activity during interview, by circling (a) hypoactive, (b) hyperactive, or (c) elements of both present.

- ☐ 0: none (normal psychomotor activity)
- ☐ a b c 1: mild (hypoactivity is barely noticeable, expressed as slightly slowing of movement. Hyperactivity is barely noticeable or appears as simple restlessness.)
- ☐ a b c 2: moderate (hypoactivity is undeniable, with marked reduction in the number of movements or marked slowness of movement; subject rarely spontaneously moves or speaks. Hyperactivity is undeniable, subject moves almost constantly; in both cases, exam is prolonged as a consequence.)
- ☐ a b c 3: severe (hypoactivity is severe; patient does not move or speak without prodding or is catatonic. Hyperactivity is severe; patient is constantly moving, overreacts to stimuli, requires surveillance and/or restraint; getting through the exam is difficult or impossible.)

ITEM 10-SLEEP-WAKE CYCLE DISTURBANCE (DISORDER OF AROUSAL): Rate patient's ability to either sleep or stay awake at the appropriate times. Utilize direct observation during the interview, as well as reports from nurses, family, patient, or charts describing sleep-wake cycle disturbance over the past several hours or since last examination. Use observations of the previous night for morning evaluations only.

- ☐ 0: none (at night, sleeps well; during the day, has no trouble staying awake)
- ☐ 1: mild (mild deviation from appropriate sleepfulness and wakefulness states: at night, difficulty falling asleep or transient night awakenings, needs medication to sleep well; during the day, reports periods of drowsiness or, during the interview, is drowsy but can easily fully awaken him/herself)
- ☐ 2: moderate (moderate deviations from appropriate sleepfulness and wakefulness states: at night, repeated and prolonged night awakening; during the day, reports of frequent and prolonged napping or, during the interview, can only be roused to complete wakefulness by strong stimuli)
- ☐ 3: severe (severe deviations from appropriate sleepfulness and wakefulness states: at night, sleeplessness; during the day, patient spends most of the time sleeping or, during the interview, cannot be roused to full wakefulness by any stimuli)