



The DI is an instrument for the measurement of severity of symptoms of delirium that is based solely upon observation of the individual patient, without additional information from family members, nursing staff or the patient medical chart. The DI was designed to be used in conjunction with the Mini-Mental State Exam (MMSE): at least the first five questions of the MMSE comprise the basis of observation. Additional questions may be necessary for scoring certain symptoms as noted.

### **1. INATTENTION**

- 0 Attentive.
- 1 Generally attentive but makes at least one error in spelling "WORLD" backwards.
- 2 Questions can generally be answered but subject is distractible and at times has difficulty in keeping track of questions. May have some difficulty in shifting attention to new questions or questions may have to be repeated several times.
- 3 Either unresponsive or totally unable to keep track of or answer questions. Has great difficulty in focusing attention and is often distracted by irrelevant stimuli.
- 9 Cannot assess.

### **2. DISORGANIZED THINKING**

- 0 Responses are logical, coherent and relevant.
- 1 Responses are vague or unclear.
- 2 Thought is occasionally illogical, incoherent or irrelevant.
- 3 Either unresponsive or thought is fragmented, illogical, incoherent, and irrelevant.
- 9 Cannot assess.

### **3. ALTERED LEVEL OF CONSCIOUSNESS**

- 0 Normal
- 1 Hypervigilant or hypovigilant (glassy eyed, decreased reaction to questions).
- 2 Drowsy/sleepy. Responds only to simple, loud questions.
- 3 Unresponsive or comatose.

**4. DISORIENTATION** (Additional questions on age, birth-date and birthplace may be used.)

- 0 Knows today's date ( $\pm$  1 day) and the name of the hospital.

- 1 Either does not know today's date ( $\pm$  1 day) or does not know the name of the hospital.
- 2 Either does not know the month or year or does not know that he is in the hospital.
- 3 Either unresponsive or does not know name or birth-date.
- 9 Cannot assess.

**5. MEMORY IMPAIRMENT** (Additional questions may be asked on how long patient has been in hospital, circumstances of admission.)

- 0 Recalls 3 words or details of hospitalization
- 1 Either cannot recall 1 of the words or has difficulty recalling details of the hospitalization.
- 2 Either cannot recall 2 of the 3 words or recalls very few details of the hospitalization.
- 3 Either Unresponsive or cannot recall any of the 3 words or cannot recall any details of the hospitalization.
- 9 Cannot assess.

**6. PERCEPTUAL DISTURBANCES** (Patient is asked whether she/he has had any unusual experiences or has seen or heard things that other people do not see or hear. If yes, she/he is asked whether these occur during the daytime or at night and how frequently. Patient is also observed for any evidence of disordered perception.)

- 0 Unresponsive, no perceptual disturbances observed, cannot assess.
- 1 Misinterprets stimuli (for example, interpreting a door closing as a gunshot).
- 2 Occasional non-threatening hallucinations.
- 3 Frequent, threatening hallucinations.

**7. MOTOR DISTURBANCES**

- 0 Normal
- 1 Responds well to questions but either moves frequently or is lethargic/sluggish.
- 2 Moves continuously (and may be restrained) or very slow with little spontaneous movement.
- 3 Agitated, difficult to control (restraints are required) or no voluntary movement.

**SCORING**

1. Total score is sum of 7 item scores.
2. If questions 1, 2, 4 or 5 are checked "9" replace 9 by the score of item 3.

McCusker J, Cole M, Dendukuri N, Belzile E. The Delirium Index, a measure of the severity of delirium: New findings on reliability, validity, and responsiveness. *Journal of the American Geriatrics Society*. 2004. 52(10):1744-1749.