Patient Name:

The DOS Delirium Observation Screening Scale

PLEASE COMPLETE TWICE DAILY

Hospital number: .....

Never = The described behaviour was not observed

Sometimes = The described behaviour always was observed once, or a few times, or all the time

Unknown = The patient was asleep or did not give necessary responses OR the rater does not

		Date:						**Date:**					
		Timepoint 1, e.g. am Time:.....			Timepoint 2, e.g. pm Time:.....			Timepoint 1, e.g. am Time:			Timepoint 2, e.g. pm Time:.....		
		Never	sometimes-always	unknown/unable	never	sometimes-always	unknown/unable	Never	sometimes-always	unknown/unable	never	sometimes-always	unknown/unable
1	Dozes during conversation or activities	0	1	-	0	1	-	0	1	-	0	1	-
2	Is easily distracted by stimuli from the environment	0	1	-	0	1	-	0	1	-	0	1	-
3	Maintains attention to conversation or action	1	0	-	1	0	-	1	0	-	1	0	-
4	Does not finish question or answer	0	1	-	0	1	-	0	1	-	0	1	-
5	Gives answers that do not fit the question	0	1	-	0	1	-	0	1	-	0	1	-
6	Reacts slowly to instructions	0	1	-	0	1	-	0	1	-	0	1	-
7	Thinks to be somewhere else	0	1	-	0	1	-	0	1	-	0	1	-
8	Knows which part of the day it is	1	0	-	1	0	-	1	0	-	1	0	-
9	Remembers recent event	1	0	-	1	0	-	1	0	-	1	0	-
10	Is picking, disorderly, restless	0	1	-	0	1	-	0	1	-	0	1	-
11	Pulls IV tubes, feeding tubes, catheters etc.	0	1	-	0	1	-	0	1	-	0	1	-
12	Is easily or suddenly emotional	0	1	-	0	1	-	0	1	-	0	1	-
13	Sees/hears things which are not there	0	1	-	0	1	-	0	1	-	0	1	-

<u>Researcher to complete this section.</u> A score of 3 or more = a delirious episode

Total Score				
Is a delirium indicated?	YES/ NO		YES/ NO	