

# Confusion Assessment Method (CAM)

Category: Geriatrics, Critical care | Items: 4 | Time: ~1-2 min

## Description / When to Use

Bedside delirium screen

## Instructions for Respondent

Please read each statement carefully and respond based on how you have felt over the specified time period. There are 4 items in this scale. Estimated completion time: 1-2 min.

## Scale Items

1. Acute onset and fluctuating course (1 point)
2. Inattention (1 point)
3. Disorganized thinking (1 point)
4. Altered level of consciousness (1 point)

## Response Options

Yes / No (scored as indicated per item)

## Scoring Guide

Weighted sum of all 4 items. Total range 0-4.

## Cutoff Interpretation

Score Range	Severity	Recommended Action
0-1	Delirium unlikely	Delirium unlikely.
2-2	Delirium unlikely (need both 1 AND 2)	Need item 1 + 2 plus 3 OR 4 for delirium.
3-4	Delirium likely (if criteria met)	Delirium is present when items 1 AND 2 are positive AND either 3 OR 4 is positive.

## Psychometric Properties

See original validation study for reliability and validity data.

## License

Free to use with citation.

Attribution: Inouye SK et al., Ann Intern Med 1990 (free for clinical/educational use with attribution)

## Citation (APA Format)

Inouye SK et al. Ann Intern Med. 1990;113(12):941-948.  
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*Disclaimer: The simple total here is a heuristic; the formal CAM algorithm requires items 1 AND 2 plus 3 OR 4. Educational use only.*