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Resources for the Comprehensive Geriatric Assessment based Proactive and Personalised Primary Care of the Elderly

4AT
4 A's Test

Purpose : Rapid assessment test for delirium

Admin time : 3 min.

User Friendly : High

Administered by : GP or nurse

Content : The 4AT has 4 items, each of which begins with an 'A':
[1] Alertness
[2] AMT4: Abbreviated Mental Test - 4.
[3] Attention test: Months of the Year Backwards
[4] Acute change or fluctuating course

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Revised 2014 (version 1.2)

https://www.cgakit.com/p-2-4at

4AT

Assessment test for delirium & cognitive impairment

Patient name:

Date of birth:

Patient number:

Date: **Time:**

Tester:

CIRCLE

[1] ALERTNESS

This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.

Normal (fully alert, but not agitated, throughout assessment)	**0**
Mild sleepiness for <10 seconds after waking, then normal	**0**
Clearly abnormal	**4**

[2] AMT4

Age, date of birth, place (name of the hospital or building), current year.

No mistakes	**0**
1 mistake	**1**
2 or more mistakes/untestable	**2**

[3] ATTENTION

Ask the patient: "Please tell me the months of the year in backwards order, starting at December."
To assist initial understanding one prompt of "what is the month before December?" is permitted.

Months of the year backwards	Achieves 7 months or more correctly	**0**
	Starts but scores <7 months / refuses to start	**1**
	Untestable (cannot start because unwell, drowsy, inattentive)	**2**

[4] ACUTE CHANGE OR FLUCTUATING COURSE

Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs

No	**0**
Yes	**4**

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4 or above: possible delirium +/- cognitive impairment
1-3: possible cognitive impairment
0: delirium or severe cognitive impairment unlikely (but delirium still possible if [4] information incomplete)

4AT SCORE ☐

Overview of scoring

The 4AT is scored from 0-12.

A score of 4 or more *suggests* delirium but is not diagnostic. In every case the diagnosis is reached by clinical judgement.

A score of 1-3 suggests cognitive impairment and more detailed cognitive testing and informant history-taking may be indicated.

A score of 0 does not definitively exclude delirium or cognitive impairment: more detailed testing may be needed depending on the clinical context.

The tester should take account of communication difficulties (hearing impairment, dysphasia, lack of common language) when carrying out the test and interpreting the score.

Scoring of patients unable to engage in conversation

Many patients with delirium are unable to produce meaningful speech because of drowsiness or severe inattention.

The design of the 4AT allows these patients to have a score on the test. If the patient cannot engage with the tester and attempt the AMT4 or the Attention test, then they are rated 'untestable' and given a score for this. Untestable status on both of these items yields a score of 4, which suggests possible delirium.

It is suggested that if a patient is unable to speak because of drowsiness, the tester does not record that the patient could not be assessed on the 4AT. Instead, the tester is encouraged to score the patient as having **abnormal alertness** (Item 1) and also have an **untestable result on the cognitive testing items** (Items 2 & 3). This will allow a 4AT score to be given, rather than the delirium assessment not being completed and potentially no diagnosis being made.