Alcohol Withdrawal: Screening and Management using the Clinical Institute Withdrawal Assessment for Alcohol, revised – (CIWA-Ar)

Site Applicability

St. Paul's Hospital (SPH) and Mount Saint Joseph Hospital (MSJ) Acute Care

Practice Level

RN, RPN, LPN: Basic Skill **(exception: LPNs may not administer IV direct medications)**

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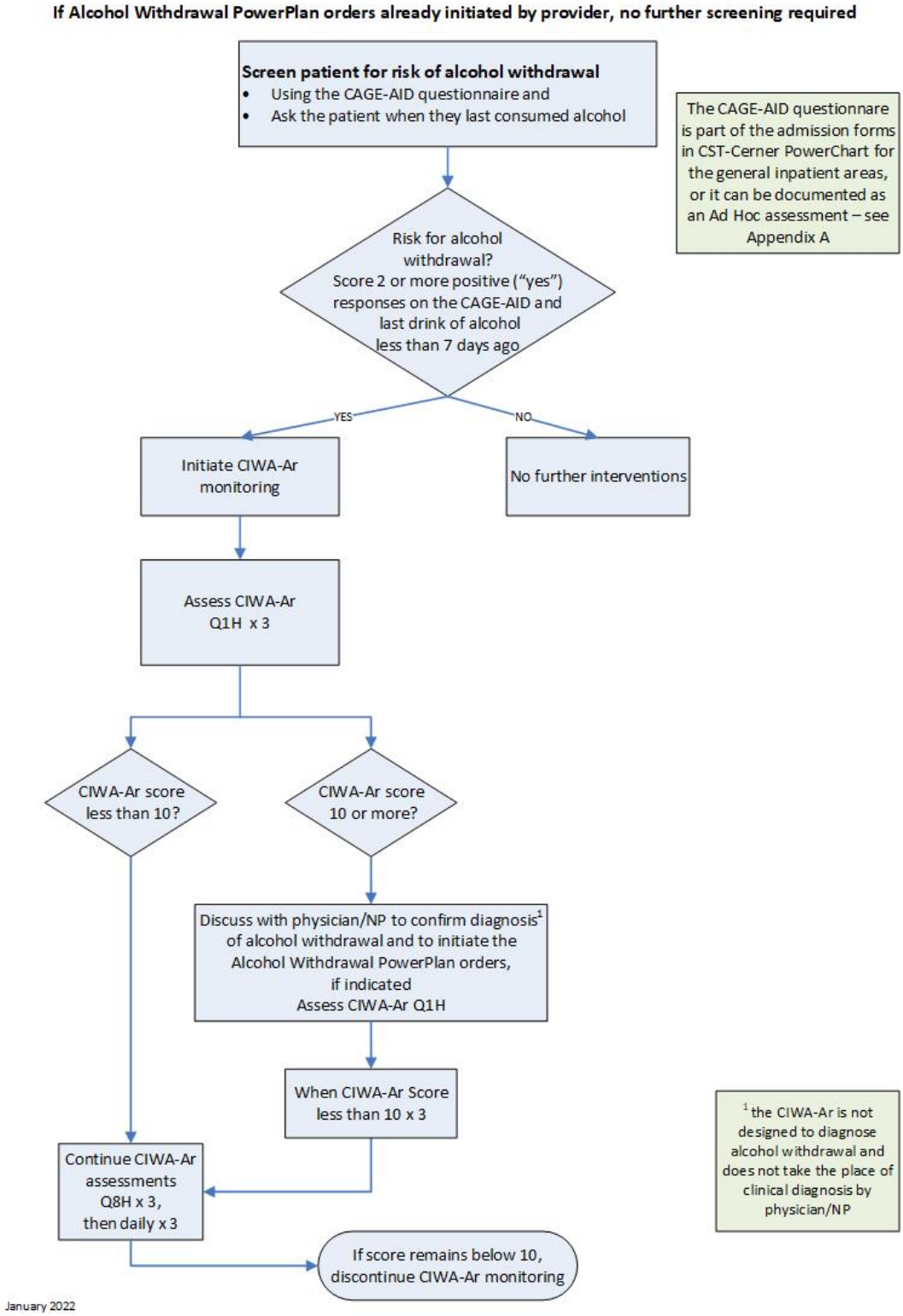
Algorithm Screening patients for alcohol use and risk of alcohol withdrawal



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Need to Know

- All patients are screened for alcohol use upon admission to hospital to determine if they may be at risk of withdrawal.
- The alcohol dependent patient may exhibit symptoms of mild withdrawal, which may progress to moderate or severe and life-threatening withdrawal rapidly and unpredictably. Symptoms of alcohol withdrawal typically begin 6 to 24 hours after the last drink and reach peak intensity at 24 to 48 hours, with symptoms resolving within 5 to 7 days (see Appendix B).
- Delirium tremens (DTs) is a severe consequence of alcohol withdrawal that requires immediate hospitalization and management and occurs 24 to 72 hours after abrupt cessation of alcohol in those with chronic alcohol use. It is characterized by the onset of severe confusion, disorientation and/or hallucinations accompanied by severe autonomic hyperactivity. DT is preventable if early symptoms of withdrawal are detected and treated.
- Alcohol withdrawal is commonly managed with the use of benzodiazepines based on assessment of withdrawal symptom severity using the Clinical Institute Withdrawal Assessment for Alcohol, revised (CIWA-Ar) scale.
- The CIWA-Ar is a 10-item scale containing subjective and objective signs and symptoms of withdrawal that guides nursing care and management and provides specific instruction for provider notification and medication administration.
- Objectives of care are early identification of patients at risk, relief of withdrawal symptoms, prevention of the progression of withdrawal, patient safety, maintenance of hydration, fluid and electrolyte balance, nutrition, rest, and support for the patient and family's goals of care.
- A diverse range of medical and psychiatric conditions may mimic and be mistaken for alcohol withdrawal (e.g., sepsis, post-op delirium, anxiety disorder), while the symptoms of alcohol withdrawal may be erroneously attributed to a medical or psychiatric condition. Therefore, **physician/provider assessment and diagnosis are essential**.
- Seek assistance from the Addiction Medicine Consult Team (AMCT) Liaison Nurse (and/or AMCT), unit Nurse Educator, Nurse Educator for Substance Use or colleagues if unfamiliar with caring for patients at risk of alcohol withdrawal or if additional support is required (see also Elsevier Clinical Skills "Alcohol Withdrawal – CE" – use Google Chrome to access).
- The AMCT may determine that the CIWA-Ar is not appropriate for certain patients and order the Objective Alcohol Withdrawal Scale (OAWS) instead (e.g., patients unable to answer CIWA-Ar questions reliably). In this case, the prescriber is directed to discontinue any existing CIWA-Ar PowerPlans. A patient will either be on CIWA-Ar *OR* OAWS – **not both at the same time and one cannot substitute for another**.

Protocol

Screening

Refer to the algorithm "Screening patients for alcohol use and risk of alcohol withdrawal".

Screen all patients for alcohol use upon admission using the CAGE-AID questionnaire and asking when their last drink was. The following patients may be at risk for alcohol withdrawal:

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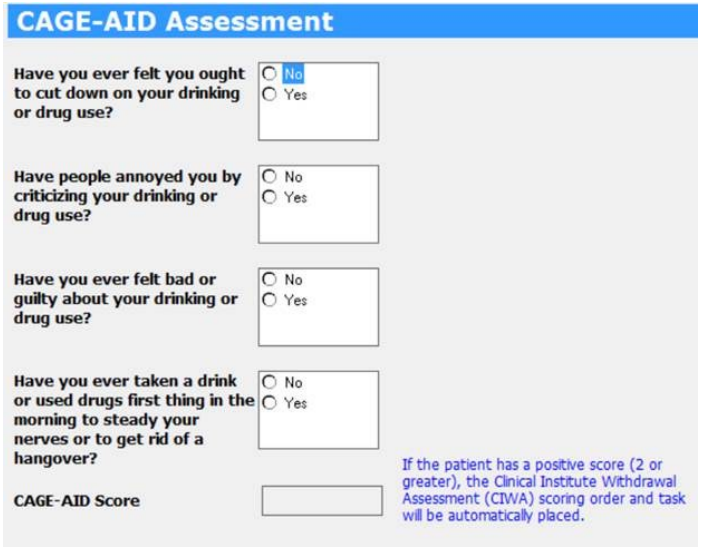
- Had their **last drink of alcohol less than 7 days ago** (last drink greater than 7 days ago is beyond withdrawal timeline)
- Score **2 or more positive responses on the CAGE-AID Assessment tool**
    - The CAGE-AID is part of the admission forms in CST-Cerner PowerChart for the general inpatient areas and can be used to identify patients with alcohol dependence
    - Care areas that do not have the CAGE-AID as part of their admission forms can document the CAGE-AID as an Ad Hoc assessment in Cerner (see Appendix A)



If the patient answers "yes" to two or more questions:

- Initiate CIWA-Ar monitoring as per the algorithm (Cerner will generate a scoring order and nursing task to complete the CIWA-Ar score)
- Notify the Most Responsible Provider (MRP) to assess need for ongoing CIWA-Ar monitoring and orders and/or possible referral to AMCT

  Nurses can independently initiate the CIWA-Ar assessment and monitor the patient if the patient's last drink of alcohol was less than 7 days ago and the patient scored 2 or more positive responses on the CAGE-AID questionnaire.

  The PowerPlan module, which includes medications to treat withdrawal symptoms and bloodwork orders, must be ordered by a prescriber.

Prescriber Orders

- The Alcohol Withdrawal Management (CIWA-Ar) PowerPlan contains orders for investigations, monitoring and medications (see Appendix C).
- The benzodiazepine orders stop automatically after 7 days. *If patient still exhibits signs of withdrawal 7 days after the PowerPlan was initiated or there are any other concerns, contact the prescriber.*

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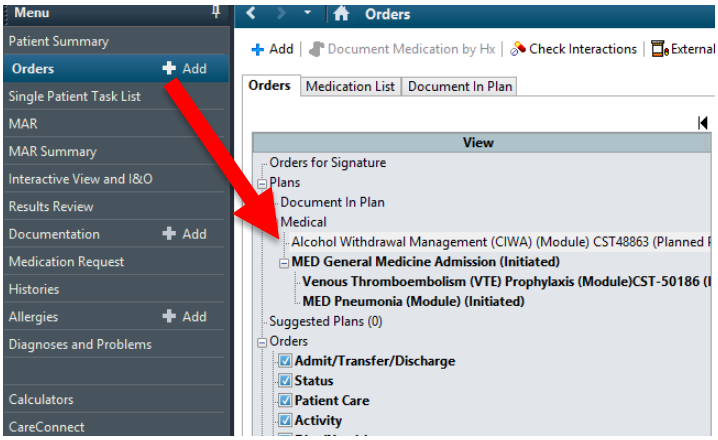
Assessment

Review Prescriber Orders

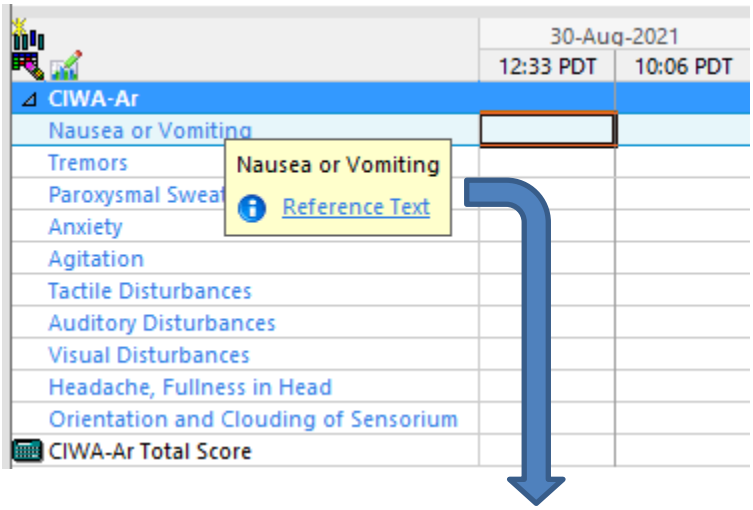
The best way to review and visualize all of the CIWA-Ar orders is by viewing the PowerPlan module itself, which is located in the "Orders" profile under "Plans":



Scoring

- Assess the patient for each of the 10 individual signs and symptoms of alcohol withdrawal.
  - If you hover the mouse over the item, there is a link to reference text. If you click the link, a pop-up window appears that lists specific questions to ask and observations to assess for each item (also see Appendix D for full list of questions).

For example, the reference text for nausea and vomiting is below:



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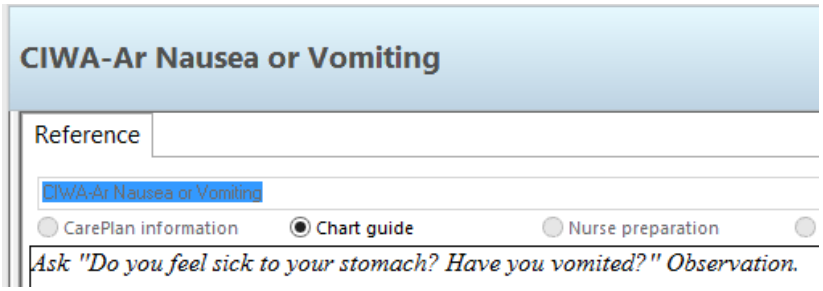
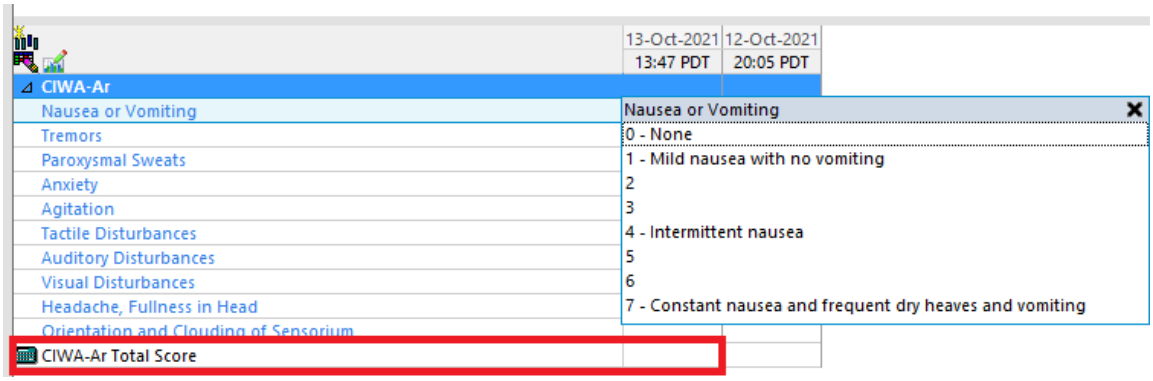


- Assign a numerical score to each item based on measure(s) of severity.
- For items containing scores that do not have accompanying text descriptions next to each numerical value, you may still assign scores to numbers without accompanying text if the symptoms that the patient reports are more severe symptoms than the numeric description above it based on your assessment.
    - For example, for scoring severity of "Nausea or Vomiting" as noted in the image below, a score of:
      1 indicates minimal nausea with no vomiting
      2 to 3 could indicate mild to moderate nausea with no vomiting
      5 could indicate repeated episodes of dry heaves with no vomiting
      6 could indicate significant nausea or dry heaves with/without vomiting
- Once all scores are entered, double click the bottom box next to "CIWA-Ar Total Score" and the total score will be calculated and displayed (see red box in image below). The maximum score is 67.



Score Interpretation

Score	Severity
0-9	Very mild withdrawal
10-15	Mild withdrawal
16-20	Moderate withdrawal
>20	Severe withdrawal

*Copied from *BCCSU, B.C. Ministry of Health and B.C. Ministry of Mental Health and Addictions Provincial Guideline for the Clinical Management of High-Risk Drinking and Alcohol Use Disorder (2019).*

Assessment Frequency

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- Perform vital sign assessment at a minimum once per shift, or as ordered.
- **Wake the patient if sleeping to perform CIWA-Ar assessments per frequency outlined below.** It can be helpful to explain the purpose and frequency of assessments to the patient.
- **Record baseline CIWA-Ar score then monitor as per PowerPlan orders outlined below at the first signs of alcohol withdrawal** (withdrawal symptoms typically commence 6 to 24 hours after the last drink). Signs and symptoms of early withdrawal include:
    - increased vital signs above the normal range (pulse, respiratory rate, blood pressure, temperature)
    - nausea and vomiting,
    - anxiety,
    - agitation,
    - headache,
    - insomnia,
    - ataxia, and/or
    - nystagmus.
    - Then, monitor CIWA-Ar q1h until score below 10 for 3 consecutive measurements, then continue q8h for 24 hours. If score remains below 10, continue to assess CIWA-Ar once daily for 3 days, then discontinue.
    - If after you have decreased the frequency of CIWA-Ar monitoring based on scores below 10 and the patient's score subsequently increases to above 10 at any time or patient's withdrawal symptoms return, resume monitoring q1h as above.
- **If CIWA-Ar score 20 or greater** (severe withdrawal), reassess q30 minutes until score below 20.
    - **Call provider immediately if CIWA-Ar score above 20 for 3 consecutive assessments.**

Interventions

1. **Implement seizure precautions** (see Seizure Management (Adult/Pediatric) for details).

2. **Administer medications as per provider's orders.**

   The PowerPlan contains orders for medication administration including PRN benzodiazepines which are administered based on symptom-triggered schedules (see Appendix C).

   - Options are LORrazepam (SL or IV if NPO) or diazepam (PO or IV if NPO). In the PRN section of the Medication Administration Record (MAR), use the mouse to hover over the orders to see the order comments to determine which order/dose is for which CIWA-Ar score.
   - **Hold benzodiazepines and notify provider ASAP if patient exhibiting signs of benzodiazepine toxicity:** respiratory rate less than 8/min, slurred speech, ataxia, disorientation, difficult to rouse, or altered mental status.
   - The medications in this PowerPlan are meant to be used in conjunction with the CIWA-Ar score and should correlate.
       - For example, if a patient is reporting anxiety but their CIWA-Ar score is less than 10, do not administer the benzodiazepines from the alcohol withdrawal orders. Patients in alcohol withdrawal with a score of less than 10 do not routinely require medication.

3. **Notify provider if:**

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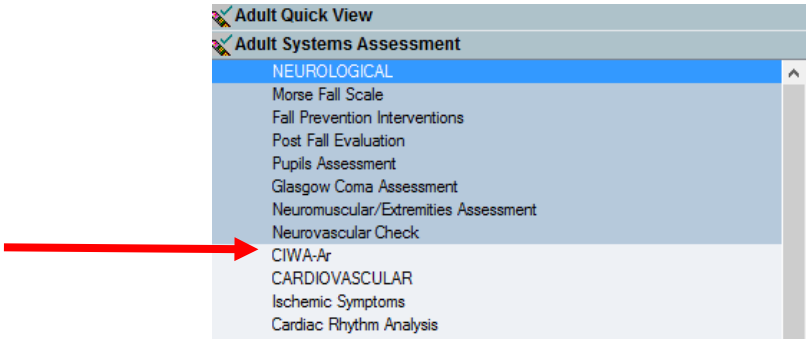
- The patient has any of the following: Pulse above 120 bpm**,** systolic blood pressure above 180 mmHg, diastolic blood pressure above 120 mmHg, or oxygen saturation below 90% or patient is hallucinating, unresponsive to treatment, or disoriented,
- CIWA-Ar score above 20 for 3 consecutive readings,
- Patient has seizures, or
- Patient is exhibiting signs of benzodiazepine toxicity.

4. **Provide supportive nursing care** (e.g., reduce sensory stimuli to promote rest, offer decaffeinated beverages and nutrition q2-4 hours and PRN unless contraindicated, implement toileting schedule with the patient).

Documentation

- Document CIWA-Ar scores under "Adult Systems Assessment" in Interactive View and I&O



- Document medication given on the MAR.
- Document all significant findings in a nursing narrative note: go to Documentation -> +Add -> under "*Type:", select "Nursing Narrative Note".
- Document patient/family education provided.

Patient and Family Education

- Discuss with the patient and/or family the potential course of alcohol withdrawal, including symptoms, and the risk of combining alcohol with other prescribed and non-prescribed substances (especially those with sedating effects, e.g., opioids).
- Ask the patient to communicate to the health care team ongoing changes in their condition (e.g., anxiety, restlessness, tremors) on assessment.
- Discuss treatment plans and goals of care with patient and family (e.g., safe consumption, rehabilitation, recovery).
- Provide information regarding existing hospital and community resources if patient requests (ask Unit Social Worker or AMCT Social Worker for details).
- See also: Canada's Low-Risk Alcohol Drinking Guidelines patient pamphlet.

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Related Documents

1. BD-00-07-40059 - Seizure Management (Adult/Pediatric)
2. B-00-13-10065 - Delirium Assessment and Care (Acute Care)
3. B-00-13-10200 - Objective Alcohol Withdrawal Scale (OAWS)
4. B-00-13-10170 - Managed Alcohol (Inpatients)
5. B-00-13-10059 - Least Restraint: Care of the Patient at Risk for or Requiring Restraint (Acute and Sub Acute Care)
6. B-00-13-10081 - Close or Constant Care: Decision Making Process
7. B-00-11-10125 - Philosophy of Care for Patients and Residents Who Use Substances
8. B-00-11-10196 - Violence Prevention in the Workplace (policy)
9. B-00-07-10011 - Falls Injury Prevention
10. B-00-11-10110 - Consent to Health Care (policy)

References

1. Berge, K. H., & Morse, R. M. (2008). Protocol-driven treatment of alcohol withdrawal in a general hospital: When theory meets practice. *Mayo Clinic Proceedings*, *83*(3), 270-271.
2. Brands, B., Kahan, M., Selby, P., & Wilson, L. (Eds.). (2000). *Management of alcohol, tobacco and other drug problems: A physician's manual*. Toronto: Centre for Addiction and Mental Health.
3. British Columbia Centre on Substance Use (BCCSU), B.C. Ministry of Health and B.C. Ministry of Mental Health and Addictions. (2019). *Provincial guideline for the clinical management of high-risk drinking and alcohol use disorder.* Retrieved from https://www.bccsu.ca/alcohol-use-disorder/
4. Elsevier. (2020, June). *Clinical skills: Alcohol withdrawal – CE.* Available on PHC Intranet.
5. Graham, A. W., Schultz, T. K., Mayo-Smith, M. F., Ries, R. K., & Wilford, B. B. (Eds.). (2003). *Principles of addiction medicine 3rd ed*. Chevy Chase, MD: American Society of Addiction Medicine.
6. Hecksel, K. A., Bostwick, J. M., Jaeger, T. M., & Cha, S. S. (2008). Inappropriate use of symptom-triggered therapy for alcohol withdrawal in the general hospital. *Mayo Clinic Proceedings, 83*(3), 274-279. doi: 10.4065/83.3.274
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8. Mayo-Smith, M. F. (1997). Pharmacological management of alcohol withdrawal: A meta-analysis and evidence-based practice guideline – American society of addiction medicine working group on pharmacological management of alcohol withdrawal. *Journal of the American Medical Association, 278*(2), 144-151.
9. NSW Government – Centre for Alcohol and Other Drugs. (2008, July 04). *Drug and alcohol withdrawal clinical practice guidelines.* Retrieved from https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2008_011.pdf
10. O'Connor, A. B., & Lang, V. J. (2008). Letters to editor: Poor care, not poor protocols, for alcohol withdrawal-3. *Mayo Clinic Proceedings, 83*(6), 726-727.

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Definitions

Benzodiazepine toxicity: Benzodiazepines taken in toxic doses; patients will primarily present with central nervous system depression ranging from mild drowsiness to a coma-like, stuporous state (severe toxicity and immediate airway management and mechanical ventilation may be required). Other symptoms may include slurred speech, ataxia, and altered mental status (see: https://www.ncbi.nlm.nih.gov/books/NBK482238/)

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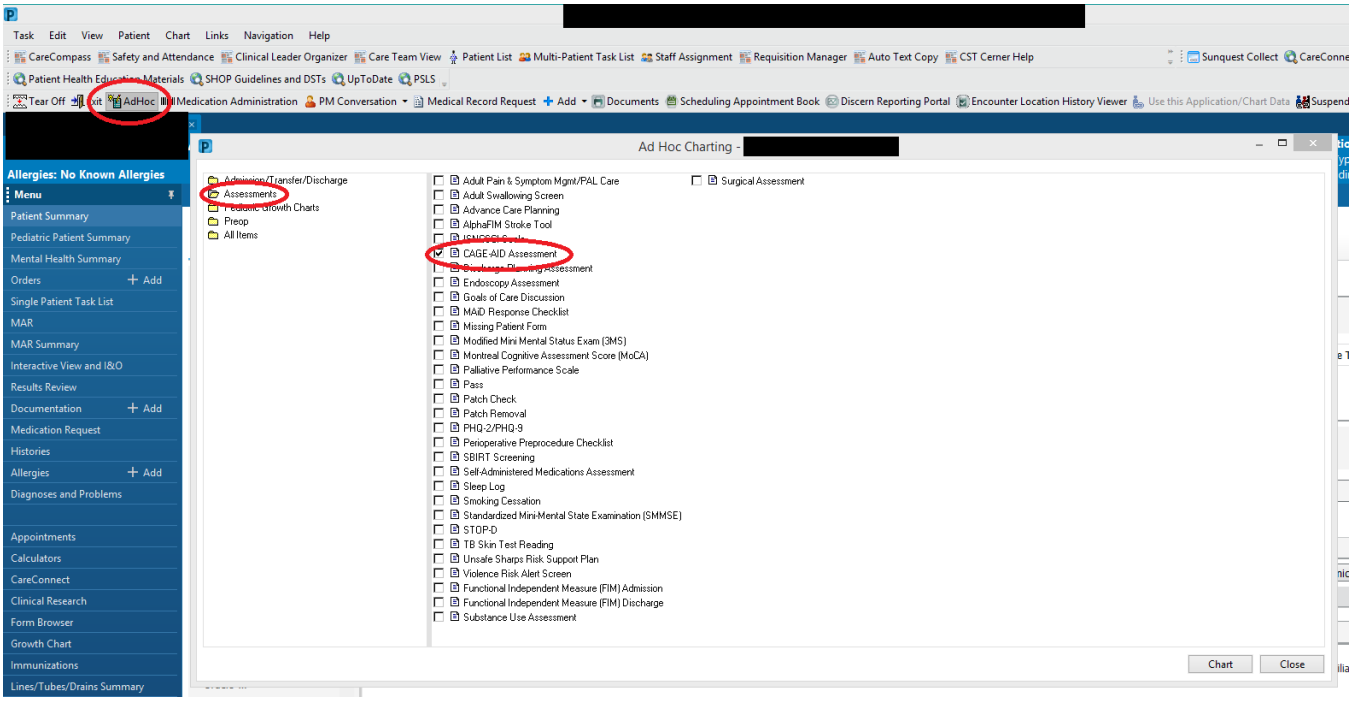
Appendix A: Documenting CAGE-AID as an Ad Hoc Assessment in CST-Cerner



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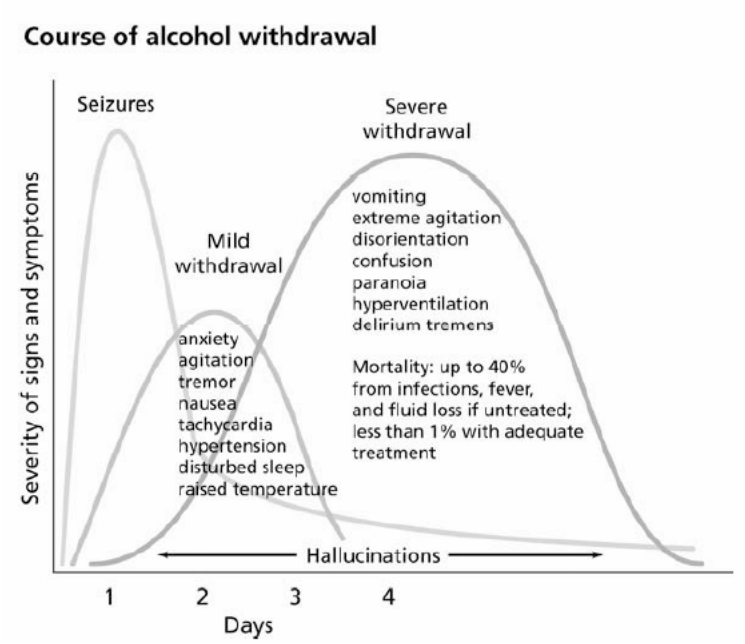
Appendix B: Progression of Alcohol Withdrawal Syndrome

Alcohol withdrawal syndrome (AWS) is the occurrence of signs and symptoms that follow the abrupt reduction or cessation of prolonged, sustained use of alcohol. Withdrawal usually does not occur when people drink in an episodic fashion as it does not lead to sustained high blood concentration of alcohol necessary to develop tolerance and withdrawal.

Symptoms of withdrawal occur because alcohol is a central nervous system depressant. Alcohol simultaneously enhances the inhibitory effects of GABA, a major inhibitory neurotransmitter, and inhibits the excitatory effects of glutamate, a major excitatory neurotransmitter. Abrupt reduction or cessation of alcohol leads to falling blood alcohol levels and reversal of these pathways resulting in over activity of the central nervous system. Severity of withdrawal depends on the daily amount and duration of alcohol use, genetic predisposition, age, medical condition of the patient and the number of prior withdrawals.

Withdrawal from alcohol is potentially fatal. A patient with alcohol use disorder may exhibit symptoms of minor withdrawal, which may progress to moderate or severe withdrawal. The onset and intensity of initial symptoms are predictive of the severity of the withdrawal.



*Copied from *NSW Drug and Alcohol Withdrawal Clinical Practice Guidelines (2008)*

Grade I - Minor Withdrawal:

- Anxiety, nausea, vomiting, tremor, tachycardia, hypertension, insomnia, and diaphoresis
- Symptoms typically appear 6 to 24 hours after the last drink or drink reduction, peak at 24 to 36 hours, and resolve within 48 to 72 hours

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Grade II - Intermediate Withdrawal:

- Hallucinations (visual, auditory, or tactile), seizures (typically non-focal and grand mal), and dysrhythmias
- Alcohol withdrawal seizures can occur at various times, but most occur within 48 hours of cessation of alcohol

Grade III - Major Withdrawal (Delirium Tremens):

- Global confusion, disorientation, severe agitation, gross tremor, marked psychomotor and autonomic hyperactivity
- This organic psychosis typically begins within 2 to 5 days of last drink and is preceded by the signs and symptoms of early withdrawal, although these may be masked or delayed by other illnesses or medications; resolves within 5 days

Morbidity and mortality can be prevented with proactive assessment, intervention and good communication between the provider and nursing staff regarding patient assessment and medication regimen.

ADDITIONAL NOTES:

- The above signs and symptoms are not specific to alcohol withdrawal. Withdrawal from other substances including opioids, benzodiazepines, and barbiturates may have overlapping presentations. Timing of symptoms may be altered if there is a concurrent withdrawal from other substances such as benzodiazepines.

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Appendix C: Alcohol Withdrawal Management (CIWA-Ar) CST-Cerner PowerPlan

Alcohol Withdrawal Management (CIWA-Ar) (Module) (Planned Pending)		
Patient Care		
☑	Seizure Precautions	T;N Notify provider if patient has seizures
☑	Communication Order	Implement CIWA-Ar
☑	Clinical Institute Withdrawal Assessment Scoring (CIWA-Ar Scoring)	T;N Record baseline CIWA-Ar score then monitor as per protocol at the first signs of alcohol withdrawal. I
☑	Notify Treating Provider	Pulse above 120, Systolic BP above 180 mmHg, Diastolic BP above 120 mmHg, or O2 saturation below
Medications		
☑	folic acid	5 mg, PO, qdaily, order duration: 3 day, drug form: tab
☐	folic acid	5 mg, IV, qdaily, order duration: 3 day, drug form: inj
☑	multivitamin with minerals (multivitamins-minerals t...	1 tab, PO, qdaily, drug form: tab
☐	multivitamin (multivitamins inj)	10 mL, IV, qdaily, drug form: inj
	Do not order magnesium sulfate if eGFR less than 30 ml/min	
☑	magnesium sulfate	5 g, IV, qdaily, order duration: 3 day
☐	thiamine	100 mg, IV, TID, order duration: 3 day, drug form: inj whenever possible give before administration of IV dextrose or IV glucose to prevent exacerbation of tl
☐ +3 day	thiamine	100 mg, PO, qdaily, drug form: tab
	For patients at elevated risk for Wernicke's encephalopathy select higher dose of IV thiamine	
☐	thiamine	500 mg, IV, TID, order duration: 2 day, drug form: inj whenever possible give before administration of IV dextrose or IV glucose to prevent exacerbation of tl
☐ +2 day	thiamine	200 mg, IV, qdaily, order duration: 5 day, drug form: inj
☐ +7 day	thiamine	100 mg, PO, qdaily, order duration: 7 day, drug form: tab
	Choose one of the following benzodiazepine options	
☑	Conditional Order - Ongoing	If/when RR less than 8/min, slurred speech, ataxia, disoriented, difficult to rouse, altered mental status
	Option 1: For adults 69 or younger or those without severe liver or respiratory disease	
☐	LORazepam	1 mg, sublingual, q1h, PRN alcohol withdrawal, order duration: 7 day, drug form: tab-sublingual For CIWA-Ar 10 to 19. Administer until CIWA-Ar score less than 10. Hold if signs of benzodiazepine
☐	LORazepam	2 mg, sublingual, q1h, PRN alcohol withdrawal, order duration: 7 day, drug form: tab-sublingual For CIWA-Ar 20 or above OR if seizure history and CIWA-Ar 15 or above. Administer until CIWA-Ar s
	If above ineffective or unable to give sublingual	
☐	LORazepam	0.5 mg, IV, q1h, PRN alcohol withdrawal, order duration: 7 day, drug form: inj For CIWA-Ar 10 to 19. If LORazepam sublingual dose ineffective or unable to give sublingual. Admi
☐	LORazepam	1 mg, IV, q1h, PRN alcohol withdrawal, order duration: 7 day, drug form: inj For CIWA-Ar 20 or greater. If LORazepam sublingual dose ineffective or unable to give sublingual. A
	Option 2: Order the following if concerned about benzodiazepine toxicity	
☐	LORazepam	0.5 mg, sublingual, q1h, PRN alcohol withdrawal, order duration: 7 day, drug form: tab-sublingual For CIWA-Ar score 10 to 19, administer until CIWA-Ar score below 10. Hold if signs of benzodiazep
☐	LORazepam	1 mg, sublingual, q1h, PRN alcohol withdrawal, order duration: 7 day, drug form: tab-sublingual For CIWA-Ar score 20 or greater, administer until CIWA-Ar score is below 20. Hold if signs of benzo
	If above ineffective or unable to give sublingual	
☐	LORazepam	0.5 mg, IV, q1h, PRN alcohol withdrawal, order duration: 7 day, drug form: inj For CIWA-Ar 10 to 19. If LORazepam sublingual dose ineffective or unable to give sublingual PO. A
☐	LORazepam	1 mg, IV, q1h, PRN alcohol withdrawal, order duration: 7 day, drug form: inj For CIWA-Ar 20 or greater. If LORazepam sublingual dose ineffective or unable to give sublingual. A
	Option 3: Diazepam	
	No IM diazepam is to be given	
☐	diazepam	10 mg, PO, q1h, PRN alcohol withdrawal, order duration: 7 day, drug form: tab For CIWA-Ar 10 to 19. Administer until CIWA-Ar score less than 10. Hold if signs of benzodiazepine
☐	diazepam	20 mg, PO, q1h, PRN alcohol withdrawal, order duration: 7 day, drug form: tab For CIWA-Ar 20 or above OR if seizure history and CIWA-Ar 15 or above. Administer until CIWA-Ar s
	If above ineffective or unable to give PO	
☐	diazepam	5 mg, IV, q1h, PRN alcohol withdrawal, order duration: 7 day, drug form: inj For CIWA-Ar 10 to 19. If diazepam PO dose ineffective or unable to give PO. Administer until CIWA-
☐	diazepam	10 mg, IV, q1h, PRN alcohol withdrawal, order duration: 7 day, drug form: inj For CIWA-Ar 20 or above OR if seizure history and CIWA-Ar 15 or above. If diazepam PO dose ineffe
	Regular benzodiazepines (consider regular dosing if severe withdrawal or seizure history)	
☐	LORazepam	1 mg, sublingual, QID, drug form: tab-sublingual hold if respiratory rate less than 10 Hold if signs of benzodiazepine toxicity: respiratory rate less than 8/min, slurred speech, ataxic, disorientated, difficult t
☐	diazepam	10 mg, PO, TID, drug form: tab hold if respiratory rate less than 10. Hold if signs of benzodiazepine toxicity: respiratory rate less than 8/min, slurred speech, ataxic, disorientated, difficult
Laboratory		
☐	CBC and Differential	Blood, Routine, Collection: T;N, once
☐	INR	Blood, Routine, Collection: T;N, once
☐	Electrolytes Panel (Na, K, Cl, CO2, Anion Gap)	Blood, Routine, Collection: T;N, once
☐	Urea	Blood, Routine, Collection: T;N, once
☐	Creatinine Level	Blood, Routine, Collection: T;N, once
☐	Magnesium Level	Blood, Routine, Collection: T;N, once
☐ +3 day	Magnesium Level	Blood, Routine, Collection: T;N, once
☐	Phosphate Level	Blood, Routine, Collection: T;N, once
☐ +3 day	Phosphate Level	Blood, Routine, Collection: T;N, once
☐	Gamma Glutamyl Transferase	Blood, Routine, Collection: T;N, once
☐	Alanine Aminotransferase	Blood, Routine, Collection: T;N, once
☐	Bilirubin Total	Blood, Routine, Collection: T;N, once
☐	Albumin Level	Blood, Routine, Collection: T;N, once
☐	Aspartate Aminotransferase (AST)	Blood, Routine, Collection: T;N, once
☐	Alanine Aminotransferase (ALT)	Blood, Routine, Collection: T;N, once
Consults/Referrals		
☐	Consult to Addiction Medicine	T;N, Reason for Consult: Alcohol withdrawal

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Appendix D: Clinical Institute Withdrawal Assessment (CIWA-Ar) Questions – used for Downtime

CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT (CIWA-Ar)FLOW SHEET

DATE:									
TIME:									
NAUSEA AND VOMITING: Ask: *"Do you feel sick to your stomach? Have you vomited?"* Observation: 0 - no nausea and no vomiting 1 - mild nausea with no vomiting 2 3 4 - intermittent nausea with dry heaves 5 6 7 - constant nausea, frequent dry heaves and vomiting									
TREMOR: Arms extended and fingers spread apart. Observation: 0 - no tremor 1 - not visible, but can be felt fingertip to fingertip 2 3 4 - moderate, with patient's arms extended 5 6 7 - severe, even with arms not extended									
TACTILE DISTURBANCES: Ask: *"Have you any itching, pins & needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?"* Observation: 0 - none 1 - very mild itching, pins and needles, burning or numbness 2 - mild itching, pins and needles, burning or numbness 3 - moderate itching, pins and needles burning or numbness 4 - moderately severe hallucinations 5 - severe hallucinations 6 - extremely severe hallucinations 7 - continuous hallucinations									
AUDITORY DISTURBANCES: Ask: *"Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things that you know aren't there?"* Observation: 0 - not present 1 - very mild harshness or ability to frighten 2 - mild harshness or ability to frighten 3 - moderate harshness or ability to frighten 4 - moderately severe hallucinations 5 - severe hallucinations 6 - extremely severe hallucinations 7 - continuous hallucinations									
PARAOXYSMAL SWEATS: Observation: 0 - no sweat visible 1 - barely perceptible sweating, palms moist 2 3 4 - beads of sweat obvious on forehead 5 6 7 - drenching sweats									
VISUAL DISTURBANCES: Ask: *"Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing you? Are you seeing things that you know aren't there?"* Observation: 0 - not present 1 - very mild sensitivity 2 - mild sensitivity 3 - moderate sensitivity 4 - moderately severe hallucinations 5 - severe hallucinations 6 - extremely severe hallucinations 7 - continuous hallucinations									
ANXIETY: Ask: *"Do you feel nervous?"* Observation: 0 - no anxiety 1 - mildly anxious 2 3 4 - moderately anxious, or guarded, so anxiety is inferred 5 6 7 - equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions									
HEADACHE, FULLNESS IN HEAD: Ask: *"Does your head feel different? Does it feel like there is a band around your head?"* Do not rate dizziness or lightheadedness. Otherwise, rate severity. 0 - not present 1 - very mild 2 - mild 3 - moderate 4 - moderately severe 5 - severe 6 - very severe 7 - extremely severe									
AGITATION: Observation: 0 - normal activity 1 - somewhat more than normal activity 2 3 4 - moderately fidgety and restless 5 6 7 - paces back and forth during most of the interview, or constantly thrashes about									
ORIENTATION AND CLOUDING OF SENSORIUM: Ask: *"What day is this? Where are you? Who am I?"* 0 - orientated and can do serial additions 1 - cannot do serial additions or is uncertain about the date 2 - disorientated for date by no more than two calendar days 3 - disorientated for date by more than two calendar days 4 - disorientated for place and/or person									
TOTAL SCORE (Max. 67)									
RATER'S INITIALS:									

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