



Assessment Report

Practice: Mindful Psychology
 Practitioner: Dr Sarah Johnson
 Client: Alex Carter
 Date: 26/04/2026

EXAMPLE REPORT — Prepared by a practitioner inside Grounded Scribe. Fictional data; not a clinical result.

4AT — 4 A's Test for Delirium

A 4-item rapid screening tool for delirium, designed for use at the bedside or in any clinical setting.

RESULTS



INTERPRETATION

Current score: 10, possible delirium, as per the 4AT author/publisher guidelines.

ABOUT THIS ASSESSMENT

Clinical Purpose

The 4AT is a rapid 4-item screening tool for delirium and cognitive impairment, designed for use at the bedside in hospital settings. It assesses alertness, cognition (abbreviated mental test), attention (months backwards), and acute change or fluctuating course. It requires no special training and takes under 2 minutes, making it practical for routine use by any healthcare professional.

Origins & Development

Developed by Alasdair MacLulich and colleagues at the University of Edinburgh, published in 2014. Created to address the critical under-detection of delirium in hospitals (estimated 60-70% missed). Validated in acute medical and surgical populations with high sensitivity (89.7%) and specificity (84.1%). It was specifically designed to be usable without training, unlike the Confusion Assessment Method (CAM) which requires trained assessors.

Australian Context

Adopted by multiple Australian hospitals and health services for routine delirium screening. Referenced in the Australian Commission on Safety and Quality in Health Care (ACSQHC) delirium clinical care standard. The Australian and New Zealand Society for Geriatric Medicine recommends routine delirium screening in older hospitalised patients, for which the 4AT is a leading tool.

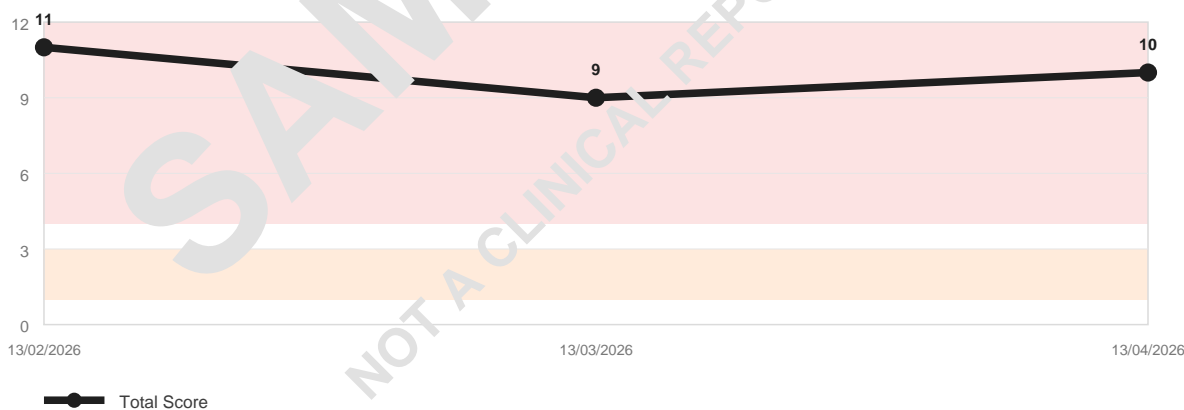


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SCORE HISTORY

Date	Score	Severity
13/02/2026	11	possible delirium
13/03/2026	9	possible delirium
13/04/2026	10	possible delirium

SCORE TRAJECTORY



RESPONSE DETAILS

#	Statement	Response
1	Alertness — This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive.	4 — Clearly abnormal (4)
2	AMT4 — Age, date of birth, place (name of the hospital or building), current year.	1 — 1 mistake (1)
3	Attention — Ask the patient: "Please tell me the months of the year in backwards order, starting at December." Record the number of months correctly sequenced starting at the end (last correct month).	1 — Starts but scores less than 7 months / refuses to start (1)
4	Acute change or fluctuating course — Evidence of significant change or fluctuation in alertness, cognition, other mental function (e.g. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs.	4 — Yes (4)

Grounded Scribe Platform

Item-level response details, score tracking over time, RCI analysis, and outcome reports are available when assessments are administered through the platform.

REFERENCES

- Bellelli G, Morandi A, Davis DH, et al. Validation of the 4AT, a new instrument for rapid delirium screening. Age Ageing. 2014;43(4):496-502.



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ACKNOWLEDGEMENT & LICENSING

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SAMPLE
NOT A CLINICAL REPORT