

Patient Delirium Burden (DEL-B-P)

Participant/Patient's Name: _____ Date: _____

Instructions: Ask the questions in the order listed. Each question should be answered yes/no/uncertain; record response in column A. If yes, ask, "If so, how upsetting was that for you?" with the following response categories: not at all distressing (0), a little bit distressing (1), somewhat distressing (2), very distressing (3), or extremely distressing (4); record responses in column B.

Questions	A. Response (yes/no/ uncertain)	B. Level of distress (range 0-4)
1. Did you ever suddenly feel confused in the hospital?		
2. Did you ever feel unsure of where you were or thought you were somewhere other than the hospital?		
3. Did you ever see or hear things that weren't really there while you were in the hospital?		
4. Did you have nightmares or vivid dreams that were intense or bothersome while you were in the hospital?		
5. Are there parts of your hospital stay that you can't remember (such as, a period of time you can't account for)?		
6. This question may not apply to you, but we ask it of everyone. Were you ever afraid of losing your mind while you were in the hospital?		
7. Were you ever restricted from getting out of bed or a chair, for example, because of a bed or chair alarm or restraints?		
8. Did you ever think that you were not going to get better?		
Scoring Instructions	Add 1 point for every "yes" (range = 0-8)	Sum all values (range = 0-32)
Column Total Scores		
Total Score (sum of columns A and B, range = 0-40)		
9. Was there anything else you found upsetting while you were in the hospital?		