DAY FORM **Questions or assistances call: +45 35 45 69 49**

Day number: |__|__| **Date |__|__| - |__|__| - |__|__|__|__|**

#	Question	Answer	Unit	Info	Validation and limits	Further comments for data manager
Delirium assessment						
D1	Was the patient in coma at any time during this day?	☐ YES ☐ NO		Yes, if the patient has any of the following on this day: • RASS score from -3 to (-5) • Ramsey sedations score 4-6 • MASS score 1-0 • GCS < 8 (without any sedation)	Required	
D2	Did the patient have delirium at any time during this day?	☐ YES ☐ NO		Yes, if the patient has any of the following on this day: • CAM-ICU (positive) • ICDSC (≥ 4 points) • DOS (>3 points) • ICD 10 (code DF05, DF050, DF058)	Required	Only if 'NO' in D1
D2a	Was the patient described as **hypo, hyper or mixed** delirious?	☐ Hypo ☐ Hyper ☐ Mixed		Defined as: • **Hypo:** if the patient is described as HYPOactive and is positive for delirium on this day. Lying still with open eyes and no clear contact (GCS >7). • **Hyper:** if the patient is described as HYPERactive and is positive for delirium on this day. Agitated and non-coorporative, pulling tubes and catheters.	Required	Only if 'YES' in D2

			• **Mixed:** if the patient is described as MIXED hypo-hyperactive and is positive for delirium on this day. *Se above for description.*		
D3	Was the patient restrained at any time during this day?	☐ YES ☐ NO	Yes, if the patient has been physically on this day	Required	
Delirium treatment assessment					
D4	Did the patient receive any treatment with **haloperidol (N05AD01)** during this day?	☐ YES ☐ NO		Required	
D4a	Total regular dose	|__|__|__|.|__| mg/day		Required	If 'YES' in D4
D4b	Total as needed dose	|__|__|__|.|__| mg/day		Required	If 'YES' in D4
D4c	Was the dose given as a prophylaxis?	☐ YES ☐ NO		Required	If 'YES' in D4
D5	Did the patient receive any treatment with **olanzapin (N05AH03)** during this day?	☐ YES ☐ NO		Required	
D5a	Total regular dose	|__|__|__|.|__| mg/day		Required	If 'YES' in D5
D5b	Total as needed dose	|__|__|__|.|__| mg/day		Required	If 'YES' in D5

D5c	Was the dose given as a prophylaxis?	☐ YES ☐ NO		Required	If 'YES' in D5
D6	Did the patient receive any treatment with **quetiapine (N05AH04)** during this day?	☐ YES ☐ NO		Required	
D6a	Total regular dose	|__|__|__|.|__|	mg/day	Required	If 'YES' in D6
D6b	Total as needed dose	|__|__|__|.|__|	mg/day	Required	If 'YES' in D6
D6c	Was the dose given as a prophylaxis?	☐ YES ☐ NO		Required	If 'YES' in D6
	Other pharmacological intervention for delirium				
D7	Did the patient receive **benzodiazepine (N05BA)** for delirium during this day?	☐ YES ☐ NO		Required	
D8	Did the patient receive **rivastigmin (N06DA03)** for delirium during this day?	☐ YES ☐ NO		Required	
D9	Did the patient receive **other** pharmacological intervention for delirium during this day?	☐ YES ☐ NO		Required	

Continuous infusion of sedatives					
D10	Did the patient receive continuous infusion of **propofol (N01AX10)** on this day?	☐ YES ☐ NO		Required	
D11	Did the patient receive continuous infusion of **midazolam (N05CD08)** on this day?	☐ YES ☐ NO		Required	
D12	Did the patient receive continuous infusion of **dexmedetomidin (N05CM18)** on this day?	☐ YES ☐ NO		Required	
D13	Did the patient receive continuous infusion of **other** sedatives on this day?	☐ YES ☐ NO		Required	
Continuous infusion of opioids for more than 2 consecutive hours					
D14	Did the patient receive continuous infusion of **remifentanil (N01AH06)** on this day for more than 2 consecutive hours?	☐ YES ☐ NO		Required	
D15	Did the patient receive continuous infusion of **sufentanil (N01AH03)** on this day for more than 2 consecutive hours?	☐ YES ☐ NO		Required	

D16	Did the patient receive continuous infusion of **fentanyl (N01AH01)** on this day for more than 2 consecutive hours?	☐ YES ☐ NO		Required	
D17	Did the patient receive continuous infusion of **morphine (N02AA01)** on this day for more than 2 consecutive hours?	☐ YES ☐ NO		Required	
D18	Did the patient receive continuous infusion of **other opioids** on this day for more than 2 consecutive hours?	☐ YES ☐ NO		Required	
Sleeping pill or insomnia medication					
D19	Did the patient receive **short acting benzodiazepine** during this day?	☐ YES ☐ NO	YES, if the patient has received any of the following during this day: • Zopiclon (N05CF01) • Zolpidem (N05CF02) • Triazolam (N05CD05) • Lormetazepam (N05CD06) • Nitrazepam (N05CD02)	Required	
D20	Did the patient receive **chlorathydrat (N05CC01)** during this day?	☐ YES ☐ NO		Required	
D21	Did the patient receive **melantonin (N05CH01)** during this day?	☐ YES ☐ NO		Required	

D22	Did the patient receive **dexmedetomidin (N05CM18) continous > 4 hours between 10 pm - 06 am** during this day?	☐ YES ☐ NO			Required	
D23	Did the patient receive **promethazin (R06AD02)** during this day?	☐ YES ☐ NO			Required	
D24	Did the patient receive **other sleeping pill or insomnia medication** during this day?	☐ YES ☐ NO			Required	
Use of life support on this day						
Treatment with continuous infusion vasopressor or inotropes						
D25	Did the patient receive treatment with **noradrenaline (C01CA03)** on this day?	☐ YES ☐ NO			Required	
D26	Did the patient receive treatment with **adrenaline (C01CA24)** on this day?	☐ YES ☐ NO			Required	
D27	Did the patient receive treatment with **dobutamine (C01CA07)** on this day?	☐ YES ☐ NO			Required	
D28	Did the patient receive treatment with **dopamine (C01CA04)** on this day?	☐ YES ☐ NO			Required	
D29	Did the patient receive treatment with **milrinone (C01CE02)** on this day?	☐ YES ☐ NO			Required	

D30	Did the patient receive treatment with **levosimendan (C01CX08)** on this day?	☐ YES ☐ NO			Required	
D31	Did the patient receive treatment with **phenylephrine (C01CA06)** on this day?	☐ YES ☐ NO			Required	
D32	Did the patient receive treatment with **vasopressin (H01BA01)** on this day?	☐ YES ☐ NO			Required	
D33	Did the patient receive **respiratory support** (invasive or non-invasive ventilation including continous CPAP or CPAP via tracheotomy) on this day?	☐ YES ☐ NO			Required	
D34	Did the patient receive any form of **renal replacement therapy** (continuous or intermittent) on this day?	☐ YES ☐ NO			Required	