

## 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
<b>Delirium assessment</b>						
D1	Was the patient in coma at any time during this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO		Yes, if the patient has any of the following on this day: <ul style="list-style-type: none"> <li>• RASS score from -3 to (-5)</li> <li>• Ramsey sedations score 4-6</li> <li>• MASS score 1-0</li> <li>• GCS &lt; 8 (with or without any sedation)</li> <li>• RLS &gt; 3 (with or without any sedation)</li> </ul>	Required	
D2	Did the patient have delirium at any time during this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO		Yes, if the patient has any of the following on this day: <ul style="list-style-type: none"> <li>• CAM-ICU (positive)</li> <li>• ICDSC (≥ 4 points)</li> <li>• DOS (&gt;3 points)</li> <li>• Nu-DESC (≥ 2 points)</li> <li>• ICD 10 (code DF05, DF050, DF058)</li> </ul>	Required	Only if 'NO' in D1
D2a	Was the patient described as <b>hypo, hyper or mixed</b> delirious?	<input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Mixed		Defined as: <ul style="list-style-type: none"> <li>• <b>Hypo:</b> 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 &gt;7 or RLS &lt; 4).</li> <li>• <b>Hyper:</b> if the patient is described as HYPERactive and is positive for</li> </ul>	Required	Only if 'YES' in D2

				delirium on this day. Agitated and non-corporative, pulling tubes and catheters. <ul style="list-style-type: none"> <li>• <b>Mixed:</b> if the patient is described as MIXED hypo-hyperactive and is positive for delirium on this day. <i>See above for description.</i></li> </ul>		
D3	Was the patient restrained at any time during this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO		Yes, if the patient has been physically on this day	Required	
<b>Delirium treatment assessment</b>						
D4	Did the patient receive any treatment with <b>haloperidol (N05AD01)</b> during this day?	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	If 'YES' in D4
D5	Did the patient receive any treatment with <b>olanzapin (N05AH03)</b> during this day?	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	If 'YES' in D5
D6	Did the patient receive any treatment with <b>quetiapine (N05AH04)</b> during this day?	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	If 'YES' in D6
<b>Other pharmacological intervention for delirium</b>						
D7	Did the patient receive <b>benzodiazepine</b> for delirium during this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO		Such as: midazolam, lorazepam, alprazolam, diazepam, oxazepam, triazolam or others.	Required	
D8	Did the patient receive <b>rivastigmin (N06DA03)</b> for delirium during this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	
D9	Did the patient receive <b>other</b> pharmacological intervention for delirium during this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	

Continuous infusion of sedatives					
D10	Did the patient receive continuous infusion of <b>propofol (N01AX10)</b> on this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO		Required	
D11	Did the patient receive continuous infusion of <b>midazolam (N05CD08)</b> on this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO		Required	
D12	Did the patient receive continuous infusion of <b>dexmedetomidin (N05CM18)</b> on this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO		Required	
D13	Did the patient receive continuous infusion of <b>other</b> sedatives on this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO		Required	
Continuous infusion of opioids for more than 2 consecutive hours					
D14	Did the patient receive continuous infusion of <b>remifentanyl (N01AH06)</b> on this day for more than 2 consecutive hours?	<input type="checkbox"/> YES <input type="checkbox"/> NO		Required	

D15	Did the patient receive continuous infusion of <b>sufentanil (N01AH03)</b> on this day for more than 2 consecutive hours?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	
D16	Did the patient receive continuous infusion of <b>fentanyl (N01AH01)</b> on this day for more than 2 consecutive hours?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	
D17	Did the patient receive continuous infusion of <b>morphine (N02AA01)</b> on this day for more than 2 consecutive hours?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	
D18	Did the patient receive continuous infusion of <b>other opioids</b> on this day for more than 2 consecutive hours?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	
<b>Sleeping pill or insomnia medication</b>						
D19	Did the patient receive <b>short acting benzodiazepine</b> during this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO		YES, if the patient has received any of the following during this day: <ul style="list-style-type: none"> <li>• Zopiclon (N05CF01)</li> <li>• Zolpidem (N05CF02)</li> <li>• Triazolam (N05CD05)</li> <li>• Lormetazepam (N05CD06)</li> <li>• Nitrazepam (N05CD02)</li> </ul>	Required	
D20	Did the patient receive <b>chloralhydrat (N05CC01)</b> during this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	

D21	Did the patient receive <b>melantonin (N05CH01)</b> during this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	
D22	Did the patient receive <b>dexmedetomidin (N05CM18) continuous &gt; 4 hours between 10 pm - 06 am</b> during this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	
D23	Did the patient receive <b>promethazin (R06AD02)</b> during this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	
D24	Did the patient receive <b>other sleeping pill or insomnia medication</b> during this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	
<b>Use of life support on this day</b>						
Treatment with continuous infusion vasopressor or inotropes						
D25	Did the patient receive treatment with <b>noradrenaline (C01CA03)</b> on this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	
D26	Did the patient receive treatment with <b>adrenaline (C01CA24)</b> on this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	
D27	Did the patient receive treatment with <b>dobutamine (C01CA07)</b> on this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	

D28	Did the patient receive treatment with <b>dopamine (C01CA04)</b> on this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	
D29	Did the patient receive treatment with <b>milrinone (C01CE02)</b> on this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	
D30	Did the patient receive treatment with <b>levosimendan (C01CX08)</b> on this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	
D31	Did the patient receive treatment with <b>phenylephrine (C01CA06)</b> on this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	
D32	Did the patient receive treatment with <b>vasopressin (H01BA01)</b> on this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	
D33	Did the patient receive <b>respiratory support</b> (invasive or non-invasive ventilation including continous CPAP or CPAP via tracheotomy) on this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	
D34	Did the patient receive any form of <b>renal replacement therapy</b> (continuous or intermittent) on this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	