

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?	<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"> • RASS score from -3 to (-5) • Ramsey sedations score 4-6 • MASS score 1-0 • GCS < 8 (with or without any sedation) • RLS > 3 (with or without any sedation) 	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"> • CAM-ICU (positive) • ICDSC (≥ 4 points) • DOS (>3 points) • Nu-DESC (≥ 2 points) • ICD 10 (code DF05, DF050, DF058) 	Required	Only if 'NO' in D1
D2a	Was the patient described as hypo, hyper or mixed delirious?	<input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Mixed		Defined as: <ul style="list-style-type: none"> • 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 or RLS < 4). • Hyper: if the patient is described as HYPERactive and is positive for 	Required	Only if 'YES' in D2

				delirium on this day. Agitated and non-corporative, pulling tubes and catheters. <ul style="list-style-type: none"> • Mixed: if the patient is described as MIXED hypo-hyperactive and is positive for delirium on this day. <i>See above for description.</i> 		
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 restrained on this day	Required	
Delirium treatment assessment						
D4	Did the patient receive any treatment with haloperidol (N05AD01) 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 olanzapin (N05AH03) 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 quetiapine (N05AH04) 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
Other pharmacological intervention for delirium						
D7	Did the patient receive benzodiazepine 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 rivastigmin (N06DA03) for delirium during this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	
D9	Did the patient receive other 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 propofol (N01AX10) on this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO		Required	
D11	Did the patient receive continuous infusion of midazolam (N05CD08) on this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO		Required	
D12	Did the patient receive continuous infusion of dexmedetomidin (N05CM18) on this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO		Required	
D13	Did the patient receive continuous infusion of other 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 remifentanyl (N01AH06) 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 sufentanil (N01AH03) 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 fentanyl (N01AH01) 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 morphine (N02AA01) 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 other opioids on this day for more than 2 consecutive hours?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required		
Sleeping pill or insomnia medication							
D19	Did the patient receive short acting benzodiazepine 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"> • Zopiclon (N05CF01) • Zolpidem (N05CF02) • Triazolam (N05CD05) • Lormetazepam (N05CD06) • Nitrazepam (N05CD02) 		Required	
D20	Did the patient receive chloralhydrat (N05CC01) during this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO				Required	

D21	Did the patient receive melantonin (N05CH01) during this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	
D22	Did the patient receive dexmedetomidin (N05CM18) continuous > 4 hours between 10 pm - 06 am during this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	
D23	Did the patient receive promethazin (R06AD02) during this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	
D24	Did the patient receive other sleeping pill or insomnia medication during this day?	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	
D26	Did the patient receive treatment with adrenaline (C01CA24) on this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	
D27	Did the patient receive treatment with dobutamine (C01CA07) on this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	

D28	Did the patient receive treatment with dopamine (C01CA04) on this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	
D29	Did the patient receive treatment with milrinone (C01CE02) on this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	
D30	Did the patient receive treatment with levosimendan (C01CX08) on this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	
D31	Did the patient receive treatment with phenylephrine (C01CA06) on this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	
D32	Did the patient receive treatment with vasopressin (H01BA01) on this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	
D33	Did the patient receive respiratory support (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 renal replacement therapy (continuous or intermittent) on this day?	<input type="checkbox"/> YES <input type="checkbox"/> NO			Required	