MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

Acute confusion, disorientation, or delirium

Structured history, interpretation & clinical review

Symptom 59 of 94
Clinical educational workbook
Version 1.0 · October 2026

Not for clinical use. This guide cannot diagnose, triage, or exclude an emergency. Seek emergency care for severe, sudden, or worsening symptoms.

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> **Document purpose**
> A structured educational history and diagnostic-reasoning workbook. Treatment is outside its scope.

Scope and safe use

Acute confusion or disorientation is a medical urgency; characterize baseline, fluctuation, attention, infection, medication, metabolic, intoxication/withdrawal, seizure, and focal neurological signs.

Not for clinical use.
This educational workbook does not diagnose, triage, estimate probability, replace examination, or exclude an emergency. If a safety-screen answer is Yes or uncertain, follow the stated action rather than continuing routine interpretation.

How to complete the workbook

- Record the current episode and the person’s usual baseline; use a witness account for events with impaired awareness.
- Check one option per question unless a clinician documents a different combination. “Not sure” is unresolved information, not a negative answer.
- Complete the safety screen before all other sections. Record exact onset or last-known-well time for sudden deficits.
- Use Section 2 only after the form is complete. More than one pattern may be relevant; urgency takes precedence.
- Use Section 3 to plan focused examination and clinician-selected investigations. No test is automatic or universally required.

Specific escalation rule

New severe headache, new focal weakness or numbness, new speech/language difficulty, reduced consciousness, a prolonged seizure, severe breathing or swallowing difficulty, sudden visual loss, or rapidly progressive weakness requires emergency assessment. Call 911 in the United States.

Section 1: Input form

Checkbox history for Acute confusion, disorientation, or delirium

1A. Immediate safety screen

Is the person acutely confused, struggling to breathe, having a seizure, or difficult to awaken?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now.

Is there new one-sided weakness, facial droop, severe imbalance, or speech/language difficulty?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now and record the onset time.

Is there sudden visual loss or a new painful red eye?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek emergency eye or emergency-department assessment now.

Is there fever with rapidly worsening illness, a new rash, severe dehydration, or an inability to keep fluids down?

☐ No ☐ Yes ☐ Not sure

If Yes: Arrange same-day or emergency assessment depending on severity and current consciousness.

> **Stop rule:** Any Yes answer triggers the action printed under that question. Any Not sure answer requires prompt in-person clarification; do not treat it as No.

1B. Timeline

How did the symptom begin?

☐ Suddenly, over seconds or minutes ☐ Over hours to days ☐ Gradually over weeks or months ☐ Longstanding or since childhood ☐ Not sure

Use the first occurrence for recurrent episodes; use the current episode for a changing symptom.

What is the overall course?

☐ One persistent episode ☐ Separate recurrent episodes ☐ Steadily worsening ☐ Fluctuating or variable ☐ Currently resolved

Has this exact pattern been assessed before?

☐ Definitely new ☐ The same pattern occurred before ☐ Present and stable for a long time ☐ Not sure

1C. Discriminating features

How did confusion develop and behave?

☐ Hours to days ☐ Fluctuating over hours ☐ Weeks or months ☐ Not sure

Is attention impaired, with drowsiness, agitation, or altered sleep-wake cycle?

☐ Poor attention or disorientation ☐ Marked drowsiness ☐ Agitation or hallucinations ☐ Not sure

Is there fever, infection, pain, dehydration, low oxygen, urinary symptoms, or recent surgery?

☐ Yes ☐ No known illness ☐ Not sure

Was there a new medicine, dose change, alcohol/benzodiazepine withdrawal, or intoxication?

☐ Yes ☐ No ☐ Not sure

1D. Associated findings

Are there other neurological symptoms—weakness, numbness, speech change, double vision, swallowing difficulty, or severe imbalance?

☐ Yes ☐ No ☐ Not sure

Are there systemic clues—fever, weight loss, cancer, infection risk, pregnancy/postpartum status, or a new medication?

☐ Yes ☐ No ☐ Not sure

How much does this affect daily activity?

☐ Noticeable but activities continue ☐ Some activities are limited ☐ Cannot perform usual activities ☐ Not sure

1E. Clinical context

Who is being assessed?

☐ Adult or adolescent ☐ Child under 12 ☐ Adult aged 65 or older

Could a medicine, substance, withdrawal, or recent dose change be relevant?

☐ No plausible contributor ☐ Yes or possibly ☐ Not reviewed

Include sedatives, dopamine-blocking drugs, stimulants, decongestants, anticholinergics, alcohol, and non-prescribed substances when relevant.

Is there a relevant neurological, muscular, metabolic, cardiovascular, autoimmune, or sleep disorder?

☐ No known relevant condition ☐ Yes ☐ Not sure

What prior information is available?

☐ A previous examination or investigation ☐ Prior records but no clear explanation ☐ No useful prior assessment ☐ Not sure

Additional history and documentation

Record exact dates/times, witness details, relevant medication doses and changes, prior investigation reports, and the person’s baseline function.

Section 2: Interpreting the input form

Answer combinations generate a differential and an assessment pathway—not a diagnosis.

> **Precedence:** Emergency safety answers override every pattern below. Otherwise, the highest-urgency fully matched pattern takes precedence. If entries are incomplete, contradictory, or match no pattern, use the unresolved-information pathway.

Pattern 1: Acute medical delirium pathway

How did confusion develop and behave? Hours to days / Fluctuating over hours
Is attention impaired, with drowsiness, agitation, or altered sleep-wake cycle? Poor attention or disorientation / Marked drowsiness / Agitation or hallucinations

Emergency warning pattern — Now

Acute fluctuating inattention or altered responsiveness requires urgent same-day/emergency medical assessment.

Differential to review:

- Delirium due to infection, hypoxia, metabolic disturbance, or systemic illness
- Stroke, seizure, encephalitis, or structural central cause

Action: Call 911 or go to the nearest emergency department now. Do not drive yourself.

Pattern 2: Medication or withdrawal-associated delirium

Was there a new medicine, dose change, alcohol/benzodiazepine withdrawal, or intoxication? Yes

Emergency warning pattern — Now

A drug or withdrawal clue with acute confusion requires urgent medical evaluation.

Differential to review:

- Medication, intoxication, or withdrawal-related delirium

Action: Call 911 or go to the nearest emergency department now. Do not drive yourself.

Pattern 3: Systemic illness-associated delirium

Is there fever, infection, pain, dehydration, low oxygen, urinary symptoms, or recent surgery? Yes
How did confusion develop and behave? Hours to days / Fluctuating over hours

Emergency warning pattern — Now

Acute confusion with systemic illness requires urgent medical assessment.

Differential to review:

- Delirium due to infection, hypoxia, metabolic disturbance, or systemic illness

Action: Call 911 or go to the nearest emergency department now. Do not drive yourself.

Pattern 4: Subacute progressive change rather than delirium

How did confusion develop and behave? Weeks or months
Is attention impaired, with drowsiness, agitation, or altered sleep-wake cycle? Poor attention or disorientation

Urgent assessment pattern — Same day

Weeks-to-months decline still needs assessment, but the differential extends beyond classic acute delirium.

Differential to review:

- Dementia with superimposed acute change or primary psychiatric episode
- Stroke, seizure, encephalitis, or structural central cause

Action: Arrange same-day medical assessment. If symptoms are rapidly worsening or severe, call 911.

Unresolved-information pathway: Acute confusion needs urgent in-person medical assessment.

Emergency warning pattern — Now

Do not guess missing answers or convert uncertainty into reassurance. Document what is unknown, perform an in-person examination, clarify the timeline with a witness or records when available, and reassess if any new feature appears.

Action: Call 911 or go to the nearest emergency department now. Do not drive yourself.

Section 3: Clinical review

Diagnostic modules and focused investigation logic

The examination comes before a test list. Select investigations only after localization, urgency, comorbidity, pregnancy status, renal function, anticoagulation, and prior results have been considered.

3.1 Delirium due to infection, hypoxia, metabolic disturbance, or systemic illness

Discriminating features: Acute fluctuating inattention with systemic illness, dehydration, low oxygen, or organ dysfunction.

Logical investigations: Urgent medical assessment with vital signs/oxygenation and targeted infection, glucose, electrolyte, organ-function and other testing.

3.2 Medication, intoxication, or withdrawal-related delirium

Discriminating features: New sedative/anticholinergic or other drug, intoxication, or alcohol/benzodiazepine withdrawal.

Logical investigations: Urgent medication/substance reconciliation and medical monitoring; severe withdrawal can be life-threatening.

3.3 Stroke, seizure, encephalitis, or structural central cause

Discriminating features: Focal signs, headache, fever/meningism, seizures, or persistent reduced consciousness.

Logical investigations: Emergency neurological assessment with brain imaging, EEG, infection evaluation or LP as clinically indicated.

3.4 Dementia with superimposed acute change or primary psychiatric episode

Discriminating features: Pre-existing cognitive impairment increases delirium risk; psychiatric diagnosis requires exclusion of acute medical causes.

Logical investigations: Establish baseline from a collateral historian and evaluate delirium triggers before attributing change to dementia or psychiatric disease.

Reassessment and documentation

- If the symptom pattern changes, repeat the safety screen and timeline rather than carrying forward an earlier interpretation.
- If a test is unrevealing but the deficit persists or progresses, revisit localization and seek specialist review; a normal result does not automatically end assessment.
- If symptoms resolve, document duration, completeness of recovery, recurrence, and any residual deficit. Resolved sudden focal symptoms can still require urgent vascular assessment.
- If the history and examination conflict, obtain collateral information and in-person review rather than forcing a single diagnostic label.

Selected references

Sources provide background standards and do not replace local emergency pathways or current specialist guidance. Accessed October 2026.

1. National Institute for Health and Care Excellence. (2018, updated 2025). *Dementia: assessment, management and support for people living with dementia and their carers (NG97)*. https://www.nice.org.uk/guidance/ng97
2. National Institute for Health and Care Excellence. (2010, updated 2023). *Delirium: prevention, diagnosis and management in hospital and long-term care (CG103)*. https://www.nice.org.uk/guidance/cg103