Inclusion Criteria: Any patient in the Emergency Department or Inpatient Med/Surg Units with any of the following:
  • Acute mental status change, acute onset hallucinations or delusions, confusion, impaired memory, alteration of attention or arousal, acute catatonia; OR
  • Clinical suspicion of delirium based on Vanderbilt Assessment for Delirium in Infants and Children (VADIC) Assessment Tool or Cornell Assessment of Pediatric Delirium (CAPD) Score
  • All patients admitted to Medical/Surgical floors will be screened for delirium

Exclusion Criteria: Patient located in the NICU, ambulatory and perioperative areas, infusion patients, PICU. If in PICU, follow PICU protocol for screening and prevention.

Etiologies to consider:
  CNS infection, fever, sepsis/end organ dysfunction (see Sepsis Pathway), Multi-system Inflammatory Syndrome in Children (see MIS-C Pathway), hypoxemia, hypoglycemia, electrolyte abnormality, CNS abnormality, intoxication, autoimmune encephalitis, SLE, vasculitis, drug withdrawal, metabolic disease, neoplasm

Phase of Care - Navigation Links
  Emergency Department
  Inpatient and ED (Zone C) Management
  Inpatient Prevention and Screening
  Inpatient Evaluation and Work Up

Scoring Tools - Navigation Links
  Appendix A: Vanderbilt Assessment for Delirium in Infants and Children (VADIC) Assessment Tool
  Appendix B: Cornell Assessment of Pediatric Delirium (CAPD) Score
  Appendix C: Developmental Anchors
CLINICAL PATHWAY: Delirium - Emergency Department Care

**Etiologies to consider:**
- CNS infection, fever, sepsis/end organ dysfunction (see Sepsis Pathway), Multi-system Inflammatory Syndrome in Children (see MIS-C Pathway), hypoxemia, hypoglycemia, electrolyte abnormality, CNS abnormality, intoxication, autoimmune encephalitis, SLE, vasculitis, drug withdrawal, metabolic disease, neoplasm

**Specific etiology likely?**

- **YES** → Proceed with disease specific management
- **NO**

**Initial Workup:**
- Labs:
  - iStat chem 10, CBC, CRP, ESR, ammonia, PT/PTT/INR, TSH, free T4, VBG or CBG, AST, ALT, EtOH level, ANA
- Urine:
  - toxicology screen
- Imaging:
  - STAT head CT without contrast

**If febrile:**
- Blood and urine cultures
- Strongly consider LP: cell count with differential, protein, glucose, gram stain and culture, HSV PCR, enterovirus PCR, opening pressure. Ask lab to hold 3 mL CSF for further studies.
- Begin all empiric IV antimicrobials listed below:
  - Ceftriaxone IV 100 mg/kg/day q12hr (max 2,000 mg/dose) x48 hours AND
  - Vancomycin IV x48 hours
    - <52 weeks PMA ǂ about <3 mo old: 15 mg/kg q8hr or as determined by pharmacy based on estimated AUC
    - 52 weeks PMA ǂ about 3 months old – 11 years old: 70 mg/kg/day div q6hr
    - 12 yrs old: 60 mg/kg/day div q6hr AND
    - Acyclovir 20 mg/kg/dose IV q8hr until HSV studies negative

  ǂPMA (Post-Menstrual Age) = gestational age + postnatal age

**≥1 of the following?**

- Ongoing delirium.
- Etiology unclear and symptoms persist. Further workup, evaluation, and treatment required.
- Medical etiology identified, admission criteria met for that diagnosis.

**Admit to Inpatient (Med/Surg vs ICU based on attending discretion.)**

**YES**
- Continue screening, evaluation, and treatment per the Inpatient Prevention and Inpatient Evaluation & Work Up
- Initiate Delirium Management upon admission

**Consider following consultations in ED as appropriate (may recommend LP, EEG, Brain MRI, further lab testing)**

- Neurology: if concern for seizure, abnormal EEG, movement disorder, abnormal neurological imaging or focal deficit, or other neurologic diagnosis
- Rheumatology: if autoimmune process suspected
- Psychiatry: to assist with recognition/diagnosis of delirium (utilizing the VADIC assessment tool – Appendix A); determine/confirm etiology; assist with pharm + non-pharmacological management
- ID: concern for unidentified or known complicated infectious process

**NO**
- Consider ED Social Work and/or Psychiatric consult to help determine and support behavioral health needs and establish follow up plan.

**If Med/Surg:** follow Inpatient Delirium Management, Prevention and Eval/Work Up

**RETURN TO THE BEGINNING**
CLINICAL PATHWAY: Delirium - Inpatient and Zone C Management

TREAT SUSPECTED ETIOLOGY

- Treat suspected etiology per primary and consulting teams, as appropriate

MEDICATIONS & ASSESSMENT

- Modify medication list:
  - Re-evaluate/confirm home medications
  - Minimize deliriogenic meds
  - Optimize pain control with non-pharmacologic strategies
  - Monitor and prevent withdrawal
  - Assess sedative medication need and effectiveness, wean as able
  - Melatonin for sleep optimization
  - Antipsychotics PRN agitation, in consultation with psychiatry if appropriate

  **Assessment:**
  - Consult Physical Therapy
  - Involve Child Life
  - Consult Psychiatry

NURSING CARE

- Monitoring and Safety
  - Vitals per unit policy
  - Continue monitoring for delirium via q 12 hour CAPD (Appendix B)
  - Assess fall and self-harm risk
  - Ensure safe transfers
  - Seizure precautions if necessary
  - Bed rest + compression boots if necessary
  - Reduce or avoid physical restraints
  - Engage and educate parents

  **Assessment:**
  - Consult Physical Therapy
  - Involve Child Life & music therapy
  - Promote regular bowel & bladder function

OPTIMIZE ENVIRONMENT

- How to optimize
  - Daily schedule for routine treatments/interventions
  - Address patient by name
  - Avoid startling/surprising patient
  - Reassure & reorient frequently
  - Explain treatments in simple language
  - Provide clocks within line of sight
  - Normalize day & night routine
  - Involve Child Life & music therapy
  - Promote regular bowel & bladder function

SOURCES

- Vitals per unit policy
- Continue monitoring for delirium via q 12 hour CAPD (Appendix B)
- Assess fall and self-harm risk
- Ensure safe transfers
- Seizure precautions if necessary
- Bed rest + compression boots if necessary
- Reduce or avoid physical restraints
- Engage and educate parents

SYMPTOMS IMPROVING?

NO
- Broaden differential and obtain further diagnostic testing and consults as indicated
- Continue to optimize environment and medications
- Multidisciplinary family meeting as indicated

YES
- Continue to optimize environment specifically as noted above
- Wean antipsychotic medications, in consultation with psychiatry
- Engage Rehab services as indicated
- Begin discharge planning
- Multidisciplinary family meeting as indicated

DISCHARGE CRITERIA & PLAN:

- Etiology of delirium determined with treatment plan in place, OR delirium resolved
- Outpatient treatment plan in place
- Clearance by Physical Therapy
- Safety of ambulation and ongoing care ensured
- Safety of discharge or transfer ensured
- Outpatient Rehab services in place if indicated
- Appropriate PCP and sub-specialty follow-up appointments in place
- Update PCP at the time of discharge
- Ensure family understanding of ongoing plan

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Concurrent implementation of preventive strategies and delirium screening as outlined below

Preventive Strategies

Environmental Considerations:
- Provide orienting environment (proper use of Whiteboard, clearly visible clocks)
- Promote healthy sleep
- Ensure early mobility and exercise; involve PT/OT
- Encourage family and developmentally appropriate engagement
- Please refer to Inpatient Delirium Management

Medication Considerations:
- Re-evaluation/confirmation of home medications
- Assess, prevent and manage pain effectively
- Assess sedative medication need and effectiveness, wean as able
- Monitor and prevent withdrawal
- Minimize polypharmacy and deliriogenic medications as appropriate**

Delirium Screening

High clinical suspicion of delirium:
1) CAPD ≥ 9
OR
2) Clinical recognition of delirium via the following features (≥1):
- Acute mental status change
- Acute onset of hallucination or delusions
- Confusion or impaired memory
- Alterations of attention or arousal
- New catatonic features

RN to perform routine delirium screening using CAPD (Appendix B) q12hr and document in medical record

**Deliriogenic Medications:**
- Benzodiazepines and Barbiturates
- Opioids
- Anti-cholinergics (e.g. atropine, diphenhydramine)
- Anti-convulsants (e.g. carbamazepine, phenytoin)
- Anti-depressants (e.g. tricyclics, SSRIs)
- Anti-emetics (e.g. promethazine)
- Anti-microbials and anti-virals (e.g. fluoroquinolones)
- Corticosteroids
- H2 receptor blockers (e.g. ranitidine, famotidine)
- Metoclopramide
- Muscle relaxants

Continue prevention and ongoing monitoring via CAPD q12hr and standard clinical assessments

- Notify provider from primary medical or surgical team.
- Provider to initiate a bedside assessment of patient and proceed to Inpatient Delirium Evaluation

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**CLINICAL PATHWAY:**

**Delirium – Inpatient Evaluation and Work Up**

**Etiologies to consider:**
- CNS infection, fever, sepsis/end organ dysfunction (see Sepsis Pathway), Multi-system Inflammatory Syndrome in Children (see MIS-C Pathway), hypoxemia, hypoglycemia, electrolyte abnormality, CNS abnormality, intoxication, autoimmune encephalitis, SLE, vasculitis, medication effect, drug withdrawal, metabolic disease, neoplasm

**Primary Work Up**
- Labs:
  - iStat chem 10, CBC, CRP, ESR, ammonia, PT/PTT/INR, TSH, free T4, VBG or CBG, AST, ALT, EtOH level, ANA
  - Toxicology screen
  - Consider STAT head CT without contrast based on history and physical exam

**Secondary Work Up**
- If febrile:
  - Blood and urine cultures
  - Strongly consider LP: cell count with differential, protein, glucose, gram stain and culture, HSV PCR, enterovirus PCR, opening pressure. Ask lab to hold 3 mL CSF for further studies.
  - Begin all empiric IV antimicrobials listed below:
    - Ceftriaxone IV 100 mg/kg/day q12hr (max 2,000 mg/dose) x48 hours AND
    - Vancomycin IV x48 hours:
      - <52 weeks PMA/about <3 mo old: 15 mg/kg q8hr or as determined by pharmacy based on estimated AUC
      - 52 weeks PMA/abour 3 mos–11 years old: 70 mg/kg/day div q6hr
      - 12 yrs old: 60 mg/kg/day div q8hr AND
    - Acyclovir 20 mg/kg/dose IV q8hr until HSV studies negative
- Consider following consultations (who may recommend further work up):
  - Neurology (if concern for seizure, abnormal EEG, movement disorder, abnormal neurological imaging or focal deficit, or other neurologic diagnosis)
  - Rheumatology (if a autoimmune process suspected)
  - Psychiatry (to assist with recognition/diagnosis of delirium utilizing the Vanderbilt Assessment for Delirium in Infants and Children (VADIC) assessment tool – Appendix A; determine/confirm etiology; assist with pharmac + non-pharmacological management; help with ongoing monitoring/ response to therapies; for ongoing co-management)
  - If diagnosis or treatment plan involves multidisciplinary approach, strongly consider family meeting.

**Tertiary Work Up**
- Consult Infectious Disease
- Infectious Encephalitis Panel:
  - Blood: Mycoplasma IgM/IgG, bartonella IgM/IgG, lyme IgM/IgG, West Nile IgM/IgG (June-Nov), Anaplasma Phagocytophilum IgG/IgM (June-Nov), Anaplasma (Ehrlichia) blood smear (June-Nov), Ricketsial Disease Panel (June-Nov, travel to endemic area)
  - CSF (add on to previously obtained CSF): Meningitis/Encephalitis PCR panel (Biofire; if criteria for use met), EBV PCR, Adenovirus PCR, VDRL (at risk patients), Arbovirus Ab panel (June-Nov)
  - Respiratory: Viral Respiratory Culture (Dec-May)
- Consider evaluation for Autoimmune Encephalitis:
  - Brain MRI
  - Blood: ANA, Anti-ENA, Anti-DNA, Anti-phospholipid antibodies, ANCA, Von Willebrand Factor antigen, ACE level, TPO
  - CSF; (add on to previously obtained CSF) Autoimmune Encephalitis Panel

**Treat suspected etiology as appropriate and continue delirium management**
# Vanderbilt Assessment for Delirium in Infants and Children (VADIC)

**Clinician:**  

**Patient ID:**  

<table>
<thead>
<tr>
<th>Age</th>
<th>Patient Intubated?</th>
<th>Date/Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ YES □ NO</td>
<td></td>
</tr>
</tbody>
</table>

**Pertinent medication exposure ≤ 24 hrs. prior to assessment (DRUG / DOSE):**

1.  
2.  
3.  
4.  
5.  
6.

## Level of Consciousness (Check one)

<table>
<thead>
<tr>
<th>State of current mental status – Check one option</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ At Baseline □ Acute Change □ Chronic Change</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pattern of mental status – past 24 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Stable □ Fluctuating</td>
</tr>
</tbody>
</table>

## Mental Status

<table>
<thead>
<tr>
<th>Alert and Calm</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ YES</td>
</tr>
</tbody>
</table>

## Perception

<table>
<thead>
<tr>
<th>Drowsy: Not fully alert but easily demonstrates sustained awakening with stimulation only from voice</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ YES</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hallucinations: □ auditory □ visual</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ N/A □ NO □ YES</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lethargy: Aroused to voice but difficult to maintain the aroused state</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ YES</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hyperacusis present? Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ N/A □ NO □ YES</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Obtundation: Responds to stimulation other than pain. May briefly open eyes or have movement, doesn’t interact with person or environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ YES</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Atypical response to normal stimuli? (stuffed animals, familiar toys)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ N/A □ NO □ YES</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stupor: Responsive only to pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ YES</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unable to soothe when fearful stimuli removed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ N/A □ NO □ YES</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coma: Unresponsive to pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ YES</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comments:</th>
</tr>
</thead>
</table>

## Attention and Cognition

<table>
<thead>
<tr>
<th>Decreased ability to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ NO □ YES</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Focus attention:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ NO □ YES</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sustain attention:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ NO □ YES</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Shift attention:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ NO □ YES</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Orientation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Person □ Place □ N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comments:</th>
</tr>
</thead>
</table>

## Contacts

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**CLINICAL PATHWAY:**
**Delirium Emergency Department and Inpatient**
**Appendix A: Vanderbilt Assessment for Delirium in Infants and Children (VADIC)**

**THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.**

<table>
<thead>
<tr>
<th>SLEEP-WAKE CYCLE</th>
<th>AFFECT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Normal Nap Patterns</strong> (Q2-4h infants, Q6th toddlers, QD preschool):</td>
<td>Excessive energy for age and context/environment?</td>
</tr>
<tr>
<td>□ NO □ YES</td>
<td>□ NO □ YES</td>
</tr>
<tr>
<td><strong>Nocturnal Disturbance</strong> : (initial, middle, terminal insomnia, phase shift)</td>
<td>Irritability or anger</td>
</tr>
<tr>
<td>□ NO □ YES</td>
<td>□ NO □ YES</td>
</tr>
<tr>
<td><strong>Day-Night Reversal</strong> (more difficult to recognize in infants)</td>
<td>Inconsolability</td>
</tr>
<tr>
<td>□ NO □ YES</td>
<td>□ NO □ YES</td>
</tr>
</tbody>
</table>

**Confounders present?** □ Anxiety □ Pain □ Volitional □ None

**LANGUAGE and THOUGHT**

| □ Not Present (immature development or developmental delay) | Describe baseline speech and language per parent/hospital if available: |
| □ Present | □ Appropriate |
| □ NO □ YES | □ Decreased amount |
| **Receptive Language:** | □ Decreased spontaneity |
| One - Step Command | □ Increased latency |
| □ NO □ YES | □ Change from baseline |
| Two - Step Command | □ Circumstantial |
| □ NO □ YES | □ Tangential |
| Three - Step Command | □ Obstructed due to disease or device |
| □ NO □ YES | |

**IS ACUTE DELIRIUM PRESENT?**

| □ UTA | When LOC severely depressed, unable to directly clinically assess patient AND prior clinical assessment not available. |
| □ NO | If NO consider → **Subsyndromal delirium(SS)** (Delirium probable but NOT all criteria met ): □ NO □ YES |
| □ YES | If YES then choose type → □ HYPOACTIVE □ HYPERACTIVE □ MIXED |
| Drug Withdrawal? □ N/A □ NO □ YES |

**24-HOUR assessment → IS DELIRIUM PRESENT?** □ PRESENT □ ABSENT □ SUBSYNDROMAL □ UTA

| □ 1. Acute change Mental Status | □ 3. Inattention present |
| □ 2. Fluctuating Course | □ 4. Inconsolability |
| □ 5. Change in Cognition | □ 6. Change in Language/Thought |
| □ 7. Change in Affect | □ 8. Change in Sleep/Wake Cycle |

**DELIRIUM = 1+2+3+5+7 AND 4 OR 6 OR 8**

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## Cornell Assessment of Pediatric Delirium (CAPD) Score – Revised

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the child make eye contact with the caregiver?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Are the child’s actions purposeful?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the child aware of his/her surroundings?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the child communicate needs and wants?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the child restless?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Is the child inconsolable?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the child underactive—very little movement while awake?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does it take the child a long time to respond to interactions?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*TOTAL*

Please see Appendix C – Developmental Anchors, to reference normative behaviors based on age and developmental level.
## CLINICAL PATHWAY:
### Delirium Emergency Department and Inpatient

**Appendix C: Developmental Anchors**

<table>
<thead>
<tr>
<th></th>
<th>NB</th>
<th>4 weeks</th>
<th>6 weeks</th>
<th>8 weeks</th>
<th>28 weeks</th>
<th>1 year</th>
<th>2 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Are the child’s actions purposeful?</td>
<td>Moves head to side, dominated by primitive reflexes</td>
<td>Reaches (with some discoordination)</td>
<td>Reaches</td>
<td>Symmetric movements, will passively grasp handed object</td>
<td>Reaches with coordinated smooth movement</td>
<td>Reaches and manipulates objects, tries to change position, if mobile may try to get up.</td>
<td>Reaches and manipulates objects, tries to change position, if mobile may try to get up and walk</td>
</tr>
<tr>
<td>3. Is the child aware of his/her surroundings?</td>
<td>Calm awake time</td>
<td>Awake alert time</td>
<td>Increasing awake alert time</td>
<td>May turn to smell of primary care taker</td>
<td>Facial brightening or smile in response to nodding head, frown to bell, coos</td>
<td>Strongly prefers mother, then other familiar, differentiates between novel and familiar objects</td>
<td>Prefers primary parent, then other familiar, upset when separated from familiar care takers. Comforted by familiar objects especially favorite blanket or stuffed animal</td>
</tr>
<tr>
<td>4. Does the child communicate needs and wants?</td>
<td>Cries when hungry or uncomfortable</td>
<td>Cries when hungry or uncomfortable</td>
<td>Cries when hungry or uncomfortable</td>
<td>Cries when hungry or uncomfortable</td>
<td>Vocalizes indicates about needs, e.g., hunger, discomfort, curiosity in objects, or surroundings</td>
<td>Uses single words or signs</td>
<td>3 to 4 word sentences, or signs. May indicate toilet needs, calls self or me</td>
</tr>
<tr>
<td>5. Is the child restless?</td>
<td>No sustained awake alert state</td>
<td>No sustained calm state</td>
<td>No sustained calm state</td>
<td>No sustained awake alert state</td>
<td>No sustained calm state</td>
<td>No sustained calm state</td>
<td>No sustained calm state</td>
</tr>
<tr>
<td>6. Is the child inconsolable?</td>
<td>Not soothed by parental rocking, singing, feeding, comforting actions</td>
<td>Not soothed by parental rocking, singing, feeding, comforting actions</td>
<td>Not soothed by parental rocking, singing, feeding, comforting actions</td>
<td>Not soothed by usual methods, e.g., singing, holding, talking</td>
<td>Not soothed by usual methods, e.g., singing, holding, talking, reading</td>
<td>Not soothed by usual methods, e.g., singing, holding, talking, reading, may tantrum, but can organize</td>
<td></td>
</tr>
<tr>
<td>7. Is the child underactive—very little movement while awake?</td>
<td>Little if any flexed and then relaxed state with primitive reflexes (Child should be sleeping comfortably most of the time)</td>
<td>Little if any reaching, kicking, grasping (still may be somewhat disorganized)</td>
<td>Little if any reaching, kicking, grasping (may begin to be more coordinated)</td>
<td>Little if any purposeful grasping, control of head and arm movements, such as pushing things that are noxious away</td>
<td>Little if any reaching, grasping, moving around in bed, pushing things away</td>
<td>Little if any play, efforts to sit up, pull up, and if mobile crawl or walk around</td>
<td>Little if any more elaborate play, efforts to sit up and move around, and if able to stand, walk, or jump</td>
</tr>
<tr>
<td>8. Does it take the child a long time to respond to interactions?</td>
<td>Not making sounds or reflexes active as expected (grasp, suck, moro)</td>
<td>Not making sounds or reflexes active as expected (grasp, suck, moro)</td>
<td>Not kicking or crying with noxious stimuli</td>
<td>Not cooling, smiling, or focusing gaze in response to interactions</td>
<td>Not babbling or smiling/laughing in social interactions (or even actively rejecting an interaction)</td>
<td>Not following simple directions. If verbal, not engaging in simple dialogue with words or jargon</td>
<td>Not following simple commands. If verbal, not engaging in more complex dialogue</td>
</tr>
</tbody>
</table>

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