Alcohol Withdrawal Assessment Flowsheet

Assessment Protocol a. Vitals, Assessment now b. If initial score ≥8, repeat c. If initial score <8, assess d. If indicated (see indications below) administer PRN medications as ordered and record on MAR and below.											
	Date										
	Time										
	Pulse										
	RR										
	O2 Sat										
	BP										
Assess and rate each of the following CIWA-Ar Scale:		**Refer to reverse for detailed instructions in use of the CIWA-Ar scale.**									
Nausea/Vomiting (0-7) 0 – none; 1 – mild nausea, no vomiting; 4 – intermittent nausea; 7 – constant nausea, frequent dry heaves & vomiting											
Tremors (0-7) 0 – no tremors, 1 – not visible but can be felt, 4 – moderate w/arms extended, 7 – severe, even w/arms not extended											
Anxiety (0-7) 0 – none, at ease, 1 – mild anxious, 4 – moderately anxious or Guarded, 7 – equivalent to acute panic state											
Agitation (0-7) 0 – normal activity, 1 – somewhat normal activity, 4 – moderately Fidgety/restless, 7 – paces or constantly thrashes about											
Paroxysmal Sweats (0-7) 0 – no sweats, 1 – barely perceptible sweating, palms moist 4 – beads of sweat obvious on forehead, 7 – drenching sweat											
Orientation (0-4) 0 – oriented, 1 – uncertain about date, 2 – disoriented to date by no more than 2 days, 3 – disoriented to date by >2 days; 4 – disoriented to place and/or person											
Tactile Disturbances (0-7) 0 – none, 1 – very mild itch, P&N, numbness, 2 – mild itch, P&N, burning, numbness, 3 – moderate itch, P&N, burning, numbness, 4 – moderate hallucinations, 5 – severe hallucinations, 6 – extremely severe hallucinations, 7 – continuous hallucinations											
Auditory Disturbances (0-7) 0 – not present, 1 – very mild harshness/ ability to startle, 2 - mild harshness, ability to startle, 3 – moderate harshness, ability to startle, 4 – moderate hallucinations, 5 – severe hallucinations, 6 – extremely severe hallucinations, 7 – continuous hallucinations											
Visual Disturbances (0-7) 0 – not present, 1 – very mild sensitivity, 2 – mild sensitivity, 3 – moderate sensitivity, 4 – moderate hallucinations, 5 – severe hallucinations, 6 – extremely severe hallucination 7 – continuous hallucinations											
Headache (0-7) 0 – not present, 1 – very mild, 2 – mild, 3 – moderate, 4- moderately severe, 5 – severe, 6 – very severe, 7 – extremely severe											
Total CIWA-Ar score:											
PRN med: (circle one) Diazepam Lorazepam	**Dose given (mg)** **Route**										
Time of PRN medication administration											
Assessment of response (CIWA-Ar score 30 to 60 minutes after medication administered) unless otherwise ordered											
RN Initials											

Signature/Title	Initials	Signature/Title	Initials

Patient Label

Alcohol Withdrawal Assessment Scoring Guidelines (CIWA-Ar)

Nausea/Vomiting - Rate on scale 0-7 0 – None 1 - Mild nausea with no vomiting 2 3 4 – Intermittent nausea 5 6 7 – Constant nausea and frequent dry heaves and vomiting	**Tremors** – have patient extend arms & spread fingers. Rate on scale 0-7 0 – Normal 1 – Not visible, but can be felt fingertip to fingertip 2 3 4 – Moderate, with patient's arm extended 5 6 7 – severe, even with arms not extended
Anxiety – Rate on scale 0-7 0 – No anxiety, patient at ease 1 – Mildly anxious 2 3 4 – Moderately anxious or guarded, so anxiety is inferred 5 6 7 – Equivalent to acute panic states seen in severe delirium or acute schizophrenic reactions	**Agitation** – Rate on scale 0 -7 0 – Normal activity 1 – Somewhat normal activity 2 3 4 – Moderately fidgety and restless 5 6 7 – Paces back and forth, or constantly thrashes about
Paroxysmal Sweats – Rate on scale 0-7 0 – No sweats 1 – Barely perceptible sweating, palms moist 2 3 4 – Beads of sweat obvious on forehead 5 6 7 – Drenching sweats	**Orientation and clouding of sensorium** – Ask, "What day is this? Where are you? Who am I?" Rate on Scale 0-4 0 – Oriented 1 – Cannot do serial additions or is uncertain about date 2 – Disoriented to date by no more than 2 calendar days 3 – Disoriented to date by more than 2 calendar days 4 – Disoriented to place and/or person
Tactile Disturbances – Ask "Have you experienced any itching, pins & needles sensation, burning or numbness, or a feeling of bugs crawling on or under your skin? 0 – None 1 – Very mild itching, pins & needles, burning or numbness 2 – Mild itching, pins & needles, burning or numbness 3 – Moderate itching, pins & needles, burning or numbness 4 – Moderate hallucinations 5 – Severe hallucinations 6 – Extremely severe hallucinations 7 –Continuous hallucinations	**Auditory Disturbances** – Ask "Are you more aware of sounds around you? Are they harsh? Do they startle you? Do you hear anything that disturbs you or that you know isn't there?" 0 – Not present 1 – Very mild harshness or ability to startle 2 – Mild harshness or ability to startle 3 – Moderate harshness or ability to startle 4 – Moderate hallucinations 5 – Severe hallucinations 6 – Extremely severe hallucinations 7 – Continuous hallucinations
Visual Disturbances – Ask "Does the light appear to be too bright? Is its color different than normal? Does it hurt your eyes? Are you seeing anything that disturbs you or that you know isn't there?" 0 – Not present 1 – Very mild sensitivity 2 – Mild sensitivity 3 – Moderate sensitivity 4 – Moderate hallucinations 5 – Severe hallucinations 6 – Extremely severe hallucinations 7 – Continuous hallucinations	**Headache** – Ask "Does your head feel different than usual? Does it feel like there is a band around your head?" Do not rate dizziness or lightheadedness. 0 – Not present 1 – Very Mild 2 – Mild 3 – Moderate 4 – Moderately Severe 5 – Severe 6 – Very Severe 7 – Extremely Severe

Procedure:

1. Assess and rate each of the 10 criteria of the CIWA scale. Each is rated on a scale from 0 to 7, except for "Orientation and clouding of sensorium" which is rated on scale 0 to 4. Add up the scores for all ten criteria. This is the total CIWA-Ar score for the patient at that time. Prophylactic medication should be started for any patient with a total CIWA-Ar score of 8 or greater (i.e. start on withdrawal medication).
2. Document vitals and CIWA-Ar assessment on the Withdrawal Assessment Flowsheet. Document administration of PRN Medications on the assessment as well.
3. The CIWA-Ar scale is the most sensitive tool for assessment of the patient experiencing alcohol withdrawal. Nursing assessment is vitally important. Early intervention for CIWA-Ar score of 8 or greater provides the best means to prevent the progression of withdrawal.