Niagara Health System
Système De Santé De Niagara

Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) Record Form

Affix Patient Label

Date and Time of last alcohol use:
Date (ddmmyyyy):______________________ Time (hhmm): ________

History of Withdrawal Seizures: ☐ Yes ☐ No

Assessment Protocol

- Use CIWA Scale to assess and rate each of the following 10 criteria
- Rate all items on Scale of 0 to 7 except last item is rated on a scale of 0 to 4

Date (ddmmyyyy)						
Time						
Temperature						
Pulse						
Resp. Rate						
Blood Pressure						

Nausea/Vomiting: *Ask "Do you feel sick to your stomach? Have you vomited?"*

0	1	2	3	4	5	6	7
No nausea	Mild nausea with no vomiting			Intermittent nausea with dry heaves			Constant nausea, frequent dry heaves and nausea vomiting

Tremors: *Arms extended and fingers spread apart. Observation:*

0	1	2	3	4	5	6	7
No tremor	Not visible but can be felt fingertip to fingertip			Moderate, with patient's arms extended			Severe, even with arms not extended

Paroxysmal Sweats: *Observation:*

0	1	2	3	4	5	6	7
No sweats	Barely perceptible sweating, palms moist			Beads of sweat obvious on forehead			Drenching sweats

Anxiety: *Ask "Do you feel nervous?"*

0	1	2	3	4	5	6	7
No anxiety, patient at ease	Mildly anxious			Moderately anxious, or guarded, so anxiety is inferred			Acute panic as seen in severe delirium or acute schizophrenic reactions

Agitation: *Observation:*

0	1	2	3	4	5	6	7
Normal activity;	Somewhat more than normal activity			Moderately fidgety and restless			Paces back and forth or constantly thrashes about

Tactile Disturbances: *Ask: "Have you any itching, pins and needles sensations, any burning, any numbness or do you feel bugs crawling on or around your skin?" Observation:*

0	1	2	3	4	5	6	7
None	Very mild itching, pins and needles or numbness	Mild itching, pins and needles, burning or numbness	Moderate itching, pins and needles, burning or numbness	Moderately severe hallucinations	Severe hallucinations	Extremely severe hallucinations	Continuous hallucinations

Auditory Disturbances: *Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing you? Are you hearing things you know are not there?" Observation:*

0	1	2	3	4	5	6	7
Not present	Very mild harshness or ability to frighten	Mild harshness or ability to frighten	Moderate harshness or ability frighten	Moderately severe hallucinations	Severe hallucinations	Extremely severe hallucinations	Continuous hallucinations

Visual Disturbances: *Ask "Does the light appear to be too bright? Is its colour different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation:*

0	1	2	3	4	5	6	7
Not present	Very mild sensitivity	Mild sensitivity	Moderate sensitivity	Moderately severe hallucinations	Severe hallucinations	Extremely severe hallucinations	Continuous hallucinations

Headaches, Fullness in Head: *Ask "Does your head feel different? Does it feel like there is a band around your head? Do not rate dizziness/lightheadedness. Otherwise, rate severity.*

0	1	2	3	4	5	6	7
Not present	Very mild	Mild	Moderate	Moderately severe	Severe	Very severe	Extremely severe

Orientation and Clouding of Sensorium: *Ask "What day is this? Where are you? Who am I?"*

0	1	2	3	4
Oriented and can do serial additions	Cannot do serial additions or is uncertain about date	Disoriented for date by no more than 2 calendar days	Disoriented for date by more than 2 calendar days	Disoriented for date, place and/or person

CIWA Score (Maximum 67):

Staff Initials:

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- Explain the procedure to the client/patient
- Take vital signs. These are not factored into the overall scoring but they provide important clinical information. Slight increase in these signs is common
- Ask each question as it appears on the CIWA-Ar and assign a score to each item
- Add up the number of points and document total score on the CIWA form
- Inform the client/patient of the outcome of the assessment and what to expect next (i.e. medication)
- Do not verbally contradict what the client/patient tells you
- Adjust the score based on the subjective and objective signs and symptoms

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