**SBAR**

**Physician/NP/PA Communication and Progress Note**

For New Symptoms, Signs and Other Changes in Condition

**Before Calling MD/NP/PA:**

- Evaluate the resident and complete the SBAR form (use “N/A” for not applicable)
- Check VS: BP, pulse, respiratory rate, temperature, pulse ox, and/or finger stick glucose if indicated
- Review chart: recent progress notes, labs, orders
- Review relevant INTERACT II Care Path or Acute Change in Status File Card
- Have relevant information available when reporting (i.e. resident chart, vital signs, advanced directives such as DNR and other care limiting orders, allergies, medication list)

**SITUATION**

The symptom/sign/change I’m calling about is _______________________________________________________
____________________________________________________________________________________________
This started___________________________________________________________________________________
This has gotten (circle one) worse/better/stayed the same since it started
Things that make the condition worse are ___________________________________________________________
Things that make the condition better are ___________________________________________________________
Other things that have occurred with this change are __________________________________________________

**BACKGROUND**

Primary diagnosis and/or reason resident is at the nursing home _________________________________________
Pertinent history (e.g. recent falls, fever, decreased intake, pain, SOB, other) ________________________________
_____________________________________________________________________________________________
Vital signs BP_________/__________  HR ________________  RR ________________  Temp ________________
Pulse Oximetry ____________% On RA______ on O2 at __________L/min via___________ (NC, mask)
Change in function or mobility ________________________________________________________________
Medication changes or new orders in the last two weeks _______________________________________________
Mental status changes (e.g. confusion/agitation/lethargy) _____________________________________________
GI/GU changes (circle) (e.g. nausea/vomiting/diarrhea/impaction/distension/decreased urinary output/other)
Pain level/location ____________________________________________________________
Change in intake/hydration _____________________________________________________________
Change in skin or wound status ______________________________________________________________
Labs ____________________________________________________________
Advance directives (circle) (Full code, DNR, DNI, DNH, other, not documented)
Allergies ________________________________________ Any other data ________________________________

**ASSESSMENT (RN) OR APPEARANCE (LPN)**

(For RNs): What do you think is going on with the resident? (e.g. cardiac, infection, respiratory, urinary, dehydration, mental status change?) I think that the problem may be ____________________________________________ -OR
I am not sure of what the problem is, but there had been an acute change in condition.
(For LPNs): The resident appears (e.g. SOB, in pain, more confused) ________________________________

**REQUEST**

I suggest or request (check all that apply):
- Provider visit (MD/NP/PA)
- Monitor vital signs and observe
- Lab work, x-rays, EKG, other tests
- Change in current orders
- IV or SC fluids
- New orders
- Other (specify)
- Transfer to the hospital

Staff name ________________________________________RN/LPN

Reported to: Name ____________________________ (MD/NP/PA) Date___/___/___ Time_______a.m./p.m.
If to MD/NP/PA, communicated by:  ☐ Phone  ☐ In person
Resident name ________________________________________________

(Complete a progress note on the back of this form)