SBAR Communication Form
and Progress Note

Before Calling MD / NP / PA:

☐ Evaluate the Resident: Complete relevant aspects of the SBAR form below
☐ Check Vital Signs: BP, pulse, and/or apical heart rate, temperature, respiratory rate, oximetry, and finger stick glucose, if indicated
☐ Review Record: Recent progress notes, labs, orders
☐ Review an INTERACT Care Path or Acute Change in Condition File Card, if indicated
☐ Have Relevant Information Available when Reporting
  (i.e. medical record, vital signs, advance directives such as DNR and other care limiting orders, allergies, medication list)

SITUATION

The change in condition, symptoms, or signs I am calling about is/are ____________________________________________

This started on ______/_____/______ Since this started has it gotten: ☐ Worse ☐ Better ☐ Stayed the same

Things that make the condition or symptom worse are __________________________________________________________

Things that make the condition or symptom better are __________________________________________________________

This condition, symptom, or sign has occurred before: ☐ Yes ☐ No

Treatment for last episode (if applicable) ________________________________________________________________

Other relevant information ____________________________________________________________

BACKGROUND

Resident Description
This resident is in the NH for: ☐ Post-Acute Care ☐ Long-Term Care

Primary diagnoses ____________________________________________________________

Other pertinent history (e.g. medical diagnosis of CHF, DM, COPD) __________________________________________

Medication Alerts
☐ Changes in the last week (describe below) ☐ Resident is on warfarin/coumadin: Result of last INR __________ Date _____/____/____

Allergies ____________________________________________________________

Vital Signs

BP ___________ Pulse ___________ Apical HR ___________ RR ___________ Temp ___________ Weight ______ lbs (date _____/____/____)

For CHF, edema, or weight loss: last weight before the current one was ____________________________ on ________/_____/______

Oximetry % ___________ ☐ on room air ☐ on O2 (liters/minute) ____________________________

Residents Name __________________________________________

(continued)
For the next 5 items, complete only those relevant to the change in condition. If the item is not relevant, check ‘N/A’ for not applicable.

### 1. Mental Status Changes (compared to baseline; check all that you observe)
- □ N/A
  - □ Increased confusion
  - □ New or worsening behavioral symptoms
  - □ Decreased consciousness (sleepy, lethargic)
  - □ Unresponsiveness
  - □ Other symptoms or signs of delirium (e.g. inability to pay attention, disorganized thinking)

Describe symptoms or signs _________________________________________________________________

### 2. Functional Status Changes (compared to baseline; check all that you observe)
- □ N/A
  - □ Needs more assistance with ADLs
  - □ Decreased mobility
  - □ Fall
  - □ Other (describe)
  - □ Weakness or hemiparesis
  - □ Slurred speech
  - □ Trouble swallowing

Describe symptoms or signs _________________________________________________________________

### 3. Respiratory
- □ N/A
  - □ Shortness of breath
  - □ Cough ( □ Non-productive □ Productive )
  - □ Abnormal lung sounds
  - □ Labored breathing

Describe symptoms or signs _________________________________________________________________

### 4. GI / Abdomen
- □ N/A
  - □ Nausea
  - □ Vomiting
  - □ Diarrhea
  - □ Decreased appetite
  - □ Abdominal pain
  - □ Distended abdomen
  - □ Tenderness
  - □ Decreased bowel sounds (date of last BM ______ / ______ / ______ )

Describe symptoms or signs _________________________________________________________________

### 5. GU / Urine Changes (compared to baseline; check all that you observe)
- □ N/A
  - □ Decreased urine output
  - □ Painful urination
  - □ Urinating more frequently
  - □ Needs to urinate more urgently
  - □ Blood in urine
  - □ New or worsening incontinence

Describe symptoms or signs _________________________________________________________________

### Recent Lab Results (e.g. CBC, chemistry or metabolic panel, drug levels)
________________________________________________________________________________________
________________________________________________________________________________________

### Advance Care Planning Information (the resident has orders for the following advance directives)
- □ DNR
- □ DNI (Do Not Intubate)
- □ DNH (Do Not Hospitalize)
- □ No Enteral Feeding
- □ Other Order or Living Will (specify)
________________________________________________________________________________________

### Other resident or family preferences for care
________________________________________________________________________________________

### Residents Name
_______________________________________________________________________________________

(continued)
ASSESSMENT (RN) OR APPEARANCE (LPN)

What do you think is going on with the resident?

For RNs: I think the problem may be (e.g. cardiac, infection, respiratory, dehydration) ________________________________________________________________
______________________________________________________________________________

For LPNs: The resident appears (e.g. short of breath, in pain, more confused) __________________________________________________________
______________________________________________________________________________

REQUEST

I suggest or request (check all that apply)

☐ Monitor vital signs  ☐ Lab work  ☐ X-ray  ☐ EKG  ☐ Provider visit (MD/NP/PA)
☐ Transfer to the hospital (send a copy of this form)  ☐ Other new orders (specify)

Nursing Notes (for additional information on the Change in Condition)
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Name of Family/Health Care Agent Notified: ____________________________ Date ___/___/___ Time (am/pm) __________

Reported to Primary Care Clinician (MD/NP/PA): ________________________ Date ___/___/___ Time (am/pm) __________

Staff Name (RN/LPN) and Signature ______________________________________

Residents Name ________________________________________________________