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)

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SBAR Communication Form
and Progress Note (cont'd)

INTERACT
Version 3.0 Tool

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 ______________________________

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SBAR Communication Form
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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)*

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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 ______________________

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