SBAR

Before Contacting HCP Checklist: (select all that apply)

☐Evaluate resident
☐Review recent orders and labs
☐Review health alert care path
☐Have resident chart available when reporting

SITUATION

The reason I am contacting you is:

_____

This was first identified: MM/DD/YYYY At___:___☐AM ☐PM
The condition has gotten: ☐ Worse ☐Better ☐stayed the same
What makes this condition better? ☐N/A

_____

What makes this condition worse? ☐N/A

_____

BACKGROUND

Why is this resident at LTCF?_____
Hospice: ☐Yes ☐No
Code status: ☐DNR ☐Full Code
Advance Directives: ☐Yes ☐No
Mental Status: ☐AAOX3 ☐Forgetful ☐Confused ☐Alzheimer/Dementia
Allergies:

_____

Additional Info:

_____

ASSESSMENT

Current Vital signs: T: ____ BP: _____ /_____ HR: ____ R: ____ ☐Room Air ☐Oxygen Pulse Oximetry____%
Edema: ☐1 ☐2 ☐3 ☐4 ☐N/A
Acute Mental Status Change: ☐No ☐Yes Explain: _____
Lung sounds: Right ☐Clear ☐Wheezes ☐Rhonchi ☐Rales ☐Inspiratory Gasp ☐Absent
Left ☐Clear ☐Wheezes ☐Rhonchi ☐Rales ☐Inspiratory Gasp ☐Absent
Bowel sounds: ☐Present ☐Absent
Last BM: MM/DD/YYYY At___:___☐AM ☐PM
Urinary:☐WNL ☐Decreased Volume ☐Decreased Frequency ☐Increased volume
☐Increased Frequency ☐Blood Present ☐Cloudy Urine ☐Foul Urine
Wound: ☐N/A

_____

REPORT

Please list the most relevant signs and symptoms:

_____

Please consider the following: ☐ED Evaluation ☐New Orders ☐Continue Monitor ☐X-ray, EKG, Labs etc.
Reported to _____Date: MM/DD/YYYY At___:___☐AM ☐PM
Notified: ☐Family ☐Health Care Provider ☐Other_____

Staff Member that completed this form:
First Name: _____Middle Name: _____Last Name: _____
Name of Facility:_____
Date: MM/DD/YYYY
Patient Demographics
First Name: _____Middle Name: _____Last Name: _____
Gender: ☐F ☐M
Date of Birth: MM/DD/YYYY
Family Member Name: _____
Health Care Provider Name: _____