SBAR Communication Form
and Progress Note for RNs/LPN/LVNs

Before Calling the Physician / NP / PA / other Healthcare Professional:

- □ Evaluate the Resident: Complete relevant aspects of the SBAR form below
- □ Check Vital Signs: BP, pulse, and/or apical heart rate, temperature, respiratory rate, O₂ saturation and finger stick glucose for diabetics
- □ Review Record: Recent progress notes, labs, medications, other 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 observed and evaluated is/are _____________________________________________________________

This started on ______ / ______ / ______ Since this started it has 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 facility for: □ Long-Term Care □ Post Acute Care □ Other: ____________________________________________

Primary diagnoses ____________________________________________

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

Medication Alerts
□ Changes in the last week (describe) ____________________________________________

□ Resident is on (Warfarin/Coumadin) Result of last INR: ____________ Date _____ / _____ / ______

□ Resident is on other anticoagulant (direct thrombin inhibitor or platelet inhibitor)

Resident is on: □ Hypoglycemic medication(s) / Insulin □ Digoxin

Allergies ____________________________________________

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

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

Pulse Oximetry (if indicated) _____________% on □ Room Air □ O₂ (___________)

Blood Sugar (Diabetics) ____________________________________________

Resident /Patient Name ____________________________________________ (continued)
Resident Evaluation
Note: Except for Mental and Functional Status evaluations, if the item is not relevant to the change in condition check the box for “not clinically applicable to the change in condition being reported”.

1. Mental Status Evaluation (compared to baseline; check all changes that you observe)
   - Decreased level of consciousness (sleepy, lethargic)
   - Increased confusion or disorientation
   - Memory loss (new or worsening)
   - New or worsened delusions or hallucinations
   - Other symptoms or signs of delirium (e.g., inability to pay attention, disorganized thinking)
   - Unresponsiveness
   - Other (describe)
   - No changes observed

   Describe symptoms or signs ______________________________________________________________________________________________

2. Functional Status Evaluation (compared to baseline; check all that you observe)
   - Decreased mobility
   - Needs more assistance with ADLs
   - Falls (one or more)
   - Swallowing difficulty
   - Weakness (general)
   - No changes observed

   Describe symptoms or signs ______________________________________________________________________________________________

3. Behavioral Evaluation
   - Danger to self or others
   - Depression (crying, hopelessness, not eating)
   - Social withdrawal (isolation, apathy)
   - Suicide potential
   - Verbal aggression
   - Physical aggression
   - Personality change
   - Other behavioral changes (describe)
   - No changes observed

   Describe symptoms or signs ______________________________________________________________________________________________

   Not clinically applicable to the change in condition being reported

4. Respiratory Evaluation
   - Abnormal lung sounds (rales, rhonchi, wheezing)
   - Inability to eat or sleep due to SOB
   - Labored or rapid breathing
   - Shortness of breath
   - Symptoms of common cold
   - Other respiratory changes (describe)
   - No changes observed

   Describe symptoms or signs ______________________________________________________________________________________________

   Not clinically applicable to the change in condition being reported

5. Cardiovascular Evaluation
   - Chest pain/tightness
   - Edema
   - Inability to stand without severe dizziness or lightheadedness
   - Irregular pulse (new)
   - Resting pulse >100 or <50
   - No changes observed

   Describe symptoms or signs ______________________________________________________________________________________________

   Not clinically applicable to the change in condition being reported

6. Abdominal / GI Evaluation
   - Abdominal pain
   - Abdominal tenderness
   - Constipation (date of last BM _____ / _____ / _____ )
   - Decreased/absent bowel sounds
   - Distended abdomen
   - Decreased appetite/fluid intake
   - Diarrhea
   - GI Bleeding (blood in stool or vomitus)
   - Hyperactive bowel sounds
   - Jaundice
   - Nausea and/or vomiting
   - Other (describe)
   - No changes observed

   Describe symptoms or signs ______________________________________________________________________________________________

   Not clinically applicable to the change in condition being reported
7. **GU/Urine Evaluation**

- Blood in urine
- Decreased urine output
- Lower abdominal pain or tenderness
- New or worsening incontinence
- Painful urination
- Urinating more frequently or urgency with or without other urinary symptoms
- Other (describe)
- No changes observed

Describe symptoms or signs

- Not clinically applicable to the change in condition being reported

8. **Skin Evaluation**

- Abrasion
- Blister
- Burn
- Contusion
- Discoloration
- Itching
- Laceration
- Pressure ulcer
- Puncture
- Rash
- Skin tear
- Splinter/silver
- Wound (describe)
- Other (describe)
- No changes observed

Describe symptoms or signs

- Not clinically applicable to the change in condition being reported

9. **Pain Evaluation**

**Does the resident have pain?**
- No
- Yes (describe below)

**Is the pain?**
- New
- Worsening of chronic pain

Description/location of pain:

**Intensity of Pain** (rate on scale of 1-10, with 10 being the worst): __________

**Does the resident show non-verbal signs of pain (for residents with dementia)?**
- No
- Yes (describe)

(restless, pacing, grimacing, new change in behavior)

Other information about the pain

- Not clinically applicable to the change in condition being reported

10. **Neurological Evaluation**

- Abnormal Speech
- Decreased level of consciousness
- Dizziness or unsteadiness
- Seizure
- Weakness or hemiparesis
- Other neurological symptoms (describe)
- No changes observed

Describe symptoms or signs

- Not clinically applicable to the change in condition being reported

**Advance Care Planning Information (the resident has orders for the following advanced care planning)**

- Full Code
- 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**

**Resident/Patient Name**

(continued)
 SBAR Communication Form  
and Progress Note for RNs/LPN/LVN (cont'd)

APPEARANCE
Summarize your observations and evaluation:

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

REVIEW AND NOTIFY
Primary Care Clinician Notified: ___________________________ Date _____/_____/ ____ Time (am/pm) ______
Recommendations of Primary Clinicians (if any) __________________________________

b. Check all that apply

<table>
<thead>
<tr>
<th>Testing</th>
<th>Interventions</th>
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<tbody>
<tr>
<td>□ Blood tests</td>
<td>□ New or change in medication(s)</td>
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<tr>
<td>□ EKG</td>
<td>□ Increase oral fluids</td>
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<tr>
<td>□ Urinalysis and/or culture</td>
<td>□ Oxygen (if available)</td>
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<td>□ Venous doppler</td>
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<td>□ X-ray</td>
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<td>□ Other (describe)</td>
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<td>□ IV or subcutaneous fluids</td>
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<td>□ Other (describe)</td>
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</tbody>
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☐ Transfer to the hospital (non-emergency) (send a copy of this form) ☐ Call for 911 ☐ Emergency medical transport

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

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Name of Family/Health Care Agent Notified: ___________________________ Date _____/_____/ ____ Time (am/pm) ______

Staff Name (RN/LPN/LVN) and Signature ____________________________

Resident/Patient Name ____________________________