SBAR for Assisted Living

Physician/NP/PA Communication and Progress Note
To Discuss Possible Drug Reduction for an Individual
Already Receiving an Antipsychotic Drug for Off-Label Use

Resident Name:
Date of Birth:
Room/Apt/Unit #:

Before Calling the MD/NP/PA

Evaluate the resident and complete the SBAR form
Check VS: BP, pulse, respiratory rate, neurological check, lung sound, temperature, and pain level
Review Chart for:

Psychiatric conditions and/or hospitalizations
Recent physician or psychologist progress notes
Pharmacist medication regimen review notes
Abnormal clinical and laboratory findings
Notes on possible drug side-effects

Be prepared to report on dosing changes, changes in target symptoms and potential side effects
Have relevant information available when reporting (medication list including doses, methods, and time(s) of administration)
Be prepared to have a list of all medications, including PRNs, and the individual’s medical record

S**ituation**

The drug and behavior (if problematic) I am calling about is_____________________________________
Date drug started____/____/____
Date of last dose adjustment and dosage change made ____/____/____
Individual’s symptoms have gotten worse/better/stayed the same since the drug started_______________
Have any potential side effects been noticed?___No ___Yes (If yes describe)______________________
____
Things that make the symptoms worse____
____
Things that make the symptoms better (non-pharmacological approach)___________________________
____
Other things that have occurred related to this symptom and treatment___________________________
____

B**ackground**

Primary diagnosis and/or reason person is in assisted living ______________________________________
Pertinent mental health history____
____
Behavioral concerns identified by family____
Vital signs BP____/____ HR____ RR____ Temp ____
Individual is on a scheduled pain management program ____No ____Yes
If yes, what medication interventions is the individual receiving?__________________________________
Conditions (check all those that apply)

Orthostatic hypotension
Weight gain
Increase glucose level
Urinary retention
Constipation
Sedation
Restlessness

Pacing
Drooling
Tremors
Rigidity
Slowness of movement
Jerk body responses

Lip smacking/chewing/abnormal tongue movement
Involuntary movement of extremities
Worsening confusion/delirium
Fall
Other_____________________

Resident Name:
Date of Birth:
Room/Apt/Unit #:

Medication changes or new orders in the last two weeks____
Recent Labs____
Allergies ____
Any other data ____

A **ssessment (RN) or Appearance (LPN/LVN)**
(For RNs): The individual's symptoms appear (better/worse/same) _________________________________
I think the symptoms may be related to ____
Do you believe the individual has achieved a therapeutic dose? ____ No ____Yes If yes: Do you believe dose reduction may be needed?____
(For LPNs/LVNs): The individual's symptom(s) appear (better/worse/same)_________________________

R **equest**
Other (Start/change non-pharmacological approach)
Change in/stop current med order(s)
Provider visit (MD/NP/PA)
Continued monitoring
Lab work

Staff Name ____ RN/LPN/LVN _____
Reported to: Name ____ (MD/NP/PA) _____
Date____/____/____ Time________________________ a.m/p.m.
Communicated by: Phone Left Message In person Fax Email
Family or health care proxy notified Name: ____
Date____/____/____ Time________________________ a.m/p.m.

Progress Note (Complete and place SBAR/progress note in medical record)
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Return call/message new orders from MD/NP/PA Date____/____/____ Time__________a.m/p.m.
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Signature____ RN/LPN/LVN _________

Date____/____/____ Time________________________ a.m/p.m.

This SBAR is developed specifically for off-label antipsychotic use. Communities are encouraged to modify/adapt changes to the SBAR as needed.