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

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
  ☐ Abnormal clinical and laboratory findings
  ☐ Recent physician or psychologist progress notes
  ☐ Notes on possible drug side-effects
  ☐ Pharmacist medication regimen review notes
☐ 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
Situation
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
Background
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 ___________________________
Medication changes or new orders in the last two weeks________________________________________
Recent Labs__________________________________________________________________________
Allergies____________________________________________________________________________
Any other data________________________________________________________________________

Assessment (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)_______________________

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

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)
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Return call/message new orders from MD/NP/PA Date___/___/___ Time__________ a.m./p.m.
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

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.