SBAR for Assisted Living Caregivers

Physician/NP/PA Communication and Progress Note
For New Symptoms, Signs and Other Changes in Condition

Suggested process as permitted by state regulations, professional licensure laws, and community policy

Before Calling Nurse/Supervisor:

☐ Evaluate the resident and complete the SBAR for AL caregivers form (use “N/A” for not applicable)
☐ Check VS: BP, pulse, respiratory rate, temperature, pulse ox, and/or finger stick glucose if indicated
☐ Have relevant information available when reporting (i.e. resident chart, vital signs, advanced directives such as DNR/POLST and other care limiting orders, allergies, medication list)

S

Situation
The symptom/sign/change I’m calling about is _____________________________________________________________

This started _______________________________________________________________________________________
This has gotten (circle one) worse/better/stayed the same since it started
Things that make the condition worse are ___________________________________________________________________________
Things that make the condition better are ___________________________________________________________________________
Other things that have occurred with this change are _______________________________________________________________________

B

Background
Primary reason resident is in assisted living ________________________________________________________________

Pertinent history (e.g. recent falls, fever, decreased intake, pain, SOB, other) ______________________________________

Vital signs BP _______/_______ HR ___________ RR ___________ Temp ___________

Change in function or mobility ______________________________________________________________

Medication changes or new orders in the last two weeks if known _______________________________________________

Mental status changes (e.g. confusion/agitation/lethargy/combative) ___________________________________________

GI/GU changes (circle) (e.g. nausea/vomiting/diarrhea/constipation/decreased urinary output/other) _______________

Pain level/location _______________________________________________________________

Change in appetite or taking in fluids ______________________________________________________________

Change in skin or wound status ______________________________________________________________

Advance directives (circle) Full code, DNR, POLST, DNI, DNH, other, not documented.

Allergies ______________________________________________________ Any other data _______________________________________

A

Appearance
The resident appears (e.g. SOB, in pain, more confused) __________________________________________________

R

Ready to Call
Staff name ___________________________________________________________ RN/LPN

Reported to: Name ____________________________________________ (MD/NP/PA/Nurse/Supervisor)

Date ___________ / ___________ / ___________ Time ________ a.m./p.m.

Communicated by: ☐ Phone ☐ Left Message ☐ In person ☐ Fax

☐ Family or health care proxy notified

Name ___________________________________________ Date _____ / _____ / _____ Time _____ / _____ AM/PM

Resident name _____________________________________________________________

Return call/new orders from MD/NP/PA/Nurse/Supervisor see attached or chart

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