SBAR for Assisted Living Nurses

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 MD/NP/PA:

☐ Evaluate the resident and complete the SBAR form (use “N/A” for not applicable)
☐ Check VS: BP, pulse, respiratory rate, temperature, and/or finger stick glucose if indicated
☐ Review chart if available: recent progress notes, labs, orders
☐ Review relevant INTERACT II Care Path or Acute Change in Status File Card if in use in your community
☐ 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 diagnosis and/or reason resident is in assisted living ______________________________________
Pertinent history (e.g. recent falls, fever, decreased intake, pain, SOB, other) ________________________________

Vital signs BP _____/_____  HR _____  RR _____  Temp _____
Pulse Oximetry _______% On RA_______ on O2 at _______ L/min via _______ (NC, mask)
Change in function or mobility ____________________________________________________________
Medication changes or new orders in the last two weeks ________________________________
Mental status changes (e.g. confusion/agitation/lack of energy) __________________________
GI/GU changes (circle) (e.g. nausea/vomiting/diarrhea/impaction/distension/decreased urinary output/other)____________________________
Pain level/location _________________________________________________________________
Change in intake/hydration _____________________________________________________________
Change in skin or wound status _________________________________________________________
Labs ____________________________________________________________
Advance directives (circle) Full code, DNR, DNI, DNH, POLST, other, not documented __________
Allergies __________________________ Any other data ________________________________

A ASSESSMENT (RN) OR APPEARANCE (LPN/LVN)
(For RNs): What do you think is going on with the resident? (e.g. cardiac, infection, respiratory, urinary, dehydration, mental status change?) I think that the problem may be ________________________-OR
I am not sure of what the problem is, but there had been an acute change in condition.
(For LPNs/LVNs): The resident appears (e.g. SOB, in pain, more confused) ______________________

R REQUEST
I suggest or request (check all that apply):
☐ Provider visit (MD/NP/PA)         ☐ Monitor vital signs and observe
☐ Lab work, x-rays, EKG, other tests ☐ Change in current orders __________________________
☐ New orders (see attached)_____________ ☐ Transfer to the hospital
☐ Other (specify) ______________________

Staff name ___________________________ (MD/NP/PA) Date __/___/___ Time __ a.m./p.m.

Reported to: Name __________________________ (MD/NP/PA) Date __/___/___ Time __ a.m./p.m.

If to MD/NP/PA, communicated by: ☐ Phone ☐ Left Message ☐ In person ☐ Fax

Resident name __________________________

(Complete a progress note on the back of this form)
☐ Family or health care proxy notified

Name_________________________ Date_____ / _____ / _____

Time _____ / _____ AM/PM

Progress Note

________________________________________________________________________

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Return call/message new orders from MD/NP/PA

Date _____ / _____ / _____

Time _____ / _____ AM/PM

Signature_________________________ RN/LPN/LVN Date _____ / _____ / _____

Time _____ / _____ AM/PM

Resident Name_________________________