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

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

☐ Evaluate the Resident/Patient: Complete relevant aspects of the SBAR form below
☐ Check Vital Signs: BP, pulse, and/or apical heart rate, temperature, respiratory rate, \( O_2 \) 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/Patient Description

This resident/patient is in the facility for: ☐ Long-Term Care ☐ Post Acute Care ☐ Other: ____________________________________________

Primary diagnoses ____________________________________________

Other pertinent history (e.g. medical diagnosis of HF, DM, COPD) ____________________________________________________________

Medication Alerts

☐ Changes in the last week (describe) ________________________________

☐ Resident/patient is on (Warfarin/Coumadin) Result of last INR: _____________ Date _____ / ____ / ______

☐ Resident/patient is on other anticoagulant (direct thrombin inhibitor or platelet inhibitor)
   ☐ Resident/patient is on: ☐ Hypoglycemic medication(s) / Insulin ☐ Digoxin

Allergies ________________________________________________________

Vital Signs

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

For HF, edema, or weight loss: last weight before the current one was ______________________________ on _______ / _______ / ______

Pulse Oximetry (if indicated) _____________ % on ☐ Room Air ☐ \( O_2 \) ( _____________)

Blood Sugar (Diabetics) _____________________________________________________________________________________________

Resident /Patient Name ________________________________________________________________________________________________

(continued)
### Resident/Patient 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)**
   - [ ] Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse)
   - [ ] 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
   - [ ] No changes observed

   Describe symptoms or signs

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

   Describe symptoms or signs

3. **Behavioral Evaluation**
   - [ ] Not clinically applicable to the change in condition being reported
   - [ ] 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

4. **Respiratory Evaluation**
   - [ ] Not clinically applicable to the change in condition being reported
   - [ ] Abnormal lung sounds (rales, rhonchi, wheezing)
   - [ ] Asthma (with wheezing)
   - [ ] Cough (☐ Non-productive ☐ Productive)
   - [ ] 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

5. **Cardiovascular Evaluation**
   - [ ] Not clinically applicable to the change in condition being reported
   - [ ] Chest pain/tightness
   - [ ] Edema
   - [ ] Inability to stand without severe dizziness or lightheadedness
   - [ ] Irregular pulse (new)
   - [ ] Resting pulse >100 or <50
   - [ ] Other (describe)
   - [ ] No changes observed

   Describe symptoms or signs

6. **Abdominal / GI Evaluation**
   - [ ] Not clinically applicable to the change in condition being reported
   - [ ] 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

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**Resident/Patient Name**

(continued)
### 7. GU/Urine Evaluation

- [ ] Not clinically applicable to the change in condition being reported
- [ ] 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 ____________________________________________

### 8. Skin Evaluation

- [ ] Not clinically applicable to the change in condition being reported
- [ ] Abrasion
- [ ] Blister
- [ ] Burn
- [ ] Contusion
- [ ] Discoloration
- [ ] Itching
- [ ] Laceration
- [ ] Pressure ulcer/pressure injury
- [ ] Puncture
- [ ] Rash
- [ ] Skin tear
- [ ] Splinter/silver
- [ ] Wound (describe)
- [ ] Other (describe)
- [ ] No changes observed

Describe symptoms or signs ____________________________________________

### 9. Pain Evaluation

- [ ] Not clinically applicable to the change in condition being reported

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 __________________________________________

### 10. Neurological Evaluation

- [ ] Not clinically applicable to the change in condition being reported

- [ ] Abnormal Speech
- [ ] Altered level of consciousness (hyperalert, drowsy but easily arousable, difficult to arouse, unarousable)
- [ ] Seizure
- [ ] Weakness or hemiparesis
- [ ] Dizziness or unsteadiness
- [ ] Other neurological symptoms (describe)
- [ ] No changes observed

Describe symptoms or signs ____________________________________________

Advance Care Planning Information (the resident/patient 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/patient or representative preferences for care

____________________________________________________________________

Resident/Patient Name ____________________________________________
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

Testing

☐ Blood tests
☐ EKG
☐ Urinalysis and/or culture
☐ Venous doppler
☐ X-ray
☐ Other (describe)

Interventions

☐ New or change in medication(s)
☐ IV or subcutaneous fluids
☐ Increase oral fluids
☐ Oxygen (if available)
☐ Other (describe)

☐ 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 ____________________________________________________________