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

INTERACT
Version 4.5 Tool

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** *(e.g., 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 CHF, DM, COPD, isolation for infection or communicable disease)*

_____

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 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
- ☐ Other *(describe)*
- ☐ **No changes observed**

Describe symptoms or signs_____

2. Functional Status Evaluation *(compared to baseline; check all that you observe)*

- ☐ Decreased mobility
- ☐ Needs more assistance with ADLs
- ☐ Falls (one or more)
- ☐ Swallowing difficulty
- ☐ Weakness *(general)*
- ☐ 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_____

Resident/Patient Name _____

(continued)

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5. Cardiovascular Evaluation ☐ **Not clinically applicable to the change in condition being reported**

☐ Chest pain/tightness ☐ Inability to stand without severe dizziness or lightheadedness ☐ Irregular pulse *(new)* ☐ Other *(describe)*
☐ Edema ☐ Resting pulse >100 or <50 ☐ **No changes observed**

Describe symptoms or signs _____

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

☐ Abdominal pain ☐ Decreased/absent bowel sounds ☐ GI bleeding *(blood in stool or vomitus)* ☐ Nausea and/or vomiting
☐ Abdominal tenderness ☐ Distended abdomen ☐ Other *(describe)*
☐ Constipation ☐ Decreased appetite/fluid intake ☐ Hyperactive bowel sounds ☐ **No changes observed**
(date of last BM _____) ☐ Diarrhea ☐ Jaundice

Describe symptoms or signs _____

7. GU / Urine Evaluation ☐ **Not clinically applicable to the change in condition being reported**

☐ Blood in urine ☐ New or worsening incontinence ☐ Other *(describe)*
☐ Decreased urine output ☐ Painful urination ☐ **No changes observed**
☐ Lower abdominal pain or tenderness ☐ Urinating more frequently or urgency with or without other urinary symptoms

Describe symptoms or signs _____

8. Skin Evaluation ☐ **Not clinically applicable to the change in condition being reported**

☐ Abrasion ☐ Contusion ☐ Laceration ☐ Rash ☐ Wound *(describe)*
☐ Blister ☐ Discoloration ☐ Pressure ulcer/pressure injury ☐ Skin tear ☐ Other *(describe)*
☐ Burn ☐ Itching ☐ Puncture ☐ Splinter/sliver ☐ **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 ☐ Seizure ☐ Other neurological symptoms *(describe)*
☐ Altered level of consciousness *(hyperalert, drowsy but easily arousable, difficult to arouse, unarousable)* ☐ Weakness or hemiparesis ☐ **No changes observed**
☐ Dizziness or unsteadiness

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 or family preferences for care _____

APPEARANCE

Summarize your observations and evaluation:

REVIEW AND NOTIFY

Primary Care Clinician Notified: _____ **Date** _____ **Time** _____ ○ **am** ○ **pm**

Recommendations of Primary Clinicians *(if any)*

Testing – Check *all* that apply

☐ COVID Test
If yes – check all that apply:
☐ Viral PCR (Nasal Swab)
☐ Viral PCR (Saliva Swab)
☐ POC Antigen Test
☐ Antibody Test
☐ Blood tests
☐ EKG
☐ Urinalysis and/or culture
☐ Venous doppler
☐ X-ray
☐ Other *(describe)* _____

Interventions – Check *all* that apply

☐ 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 _____