

SBAR Worksheet

Call to Physician or Nurse Practitioner



Before Calling MD/NP: ☐ Evaluate the resident and complete focused assessment (i.e. respiratory, cardiovascular) ☐ Check Vital Signs (temperature, pulse, respirations, oxygen saturation, BP) ☐ Review the Record (progress notes, labs, medications, other orders) ☐ Have relevant information available (allergies, medication lists)	NOTES:
Situation: (Introduction and overview of the problem/concern) My name isname/position I am calling from facility name/unit about resident name The problem I'm calling about is (or) I am concerned about	
Background: (Information related to the problem or concern) Resident's Diagnoses Goals of Care/Resident's Wishes Allergies Current related medications: anticoagulants antibiotics insulin/oral hypoglycemic antipsychotics analgesics other Abnormal test results: labs INR urine C&S imaging results	
Vitals Are: Temp: Pulse: Resp: Pulse Ox: BP: PPS: Relevant Labs: INR Creatinine Clearance/eGFR blood glucose Changes in the following: (describe pertinent issues/changes you are calling about) Mental Status: decreased LOC unresponsive Increased confusion/disorientation delusions/hallucinations s/sx delirium Functional Status: decreased mobility falls swallowing difficulty weakness Behavioural: risk to self or others verbal aggression physical aggression Neurologic: abnormal speech dizziness/unsteadiness weakness or hemiparesis LOC: alert/oriented confused agitated/combative unresponsive delirium Respiratory: abnormal lung sounds (wheeze/crackles/rub) dyspnea/SOB difficulty eating/sleeping due to SOB Cough (productive/non-productive) cold symptoms on O2 @ Pulse Ox Cardiovascular: chest pain/tightness Heart rate (apical) irregular pulse (new) edema dizziness/lightheadedness with standing orthopnea Abdominal/GI: abd pain tenderness distension decreased appetite/intake decreased/absent bs hyperactive bs constipation: last BM nausea/vomiting diarrhea Gl bleeding jaundice Genitourinary: dysuria urgency/frequency suprapubic/lower abd pain/ tenderness new/worse incontinence decreased urine output hematuria Musculoskeletal: pain tenderness alignment mobility edema Skin: temp dry/moist/clammy mottled cyanotic other abrasion laceration skin tear pressure ulcer Wound status: induration drainage colour Pain: onset provokes quality region/radiation timing understanding pain scale (1-10): Other: Commendation/Request	
Recommendation/Request ☐ I think the problem may be (i.e. infection, neurologic, fracture, cardiac, etc.) ☐ I think we need to (consider pharmacological/non-pharmacological strategies to manage in the LTCH) ☐ Do you want to order any tests or make changes in the current treatment plan?	