SBAR

Patient Name:

Physician/NP/PA Communication and Progress Note Date of Birth:
To Discuss Possible Drug Reduction for an Individual Medical record #:
Already Receiving an Antipsychotic Drug for Off-Label Use

Before Calling the MD/NP/PA:

__ Evaluate the patient and complete the SBAR form
__ Check VS: BP, pulse, respiratory rate, neurological check, lung sound, temperature, pain level
__ Review chart for:

- psychiatric conditions and/or hospitalizations
- recent physician or psychologist progress notes
- pharmacist medication regimen review notes
- abnormal clinical and laboratory findings
- notes on possible drug side-effects

__ Be prepared to report on dosing changes, changes in target symptoms and potential side effects
__ Have relevant information available when reporting (medication list including doses, method and time(s) of administration)
__ Be prepared to have a list of all medications, including PRNs, and the individual's medical record

Situation

The drug and behavior (if problematic) I am calling about is _____
Date drug started ___/___/___
Date of last dose adjustment and dosage change made ___/___/___
Individual's symptoms has gotten worse/better/stayed the same since the drug started _____
Have any potential side effects been noticed? __No __Yes (If yes describe)

_____
_____

Things that make the symptoms worse

_____
_____

Things that make the symptoms better (non-pharmacological approach)

_____
_____

Other things that have occurred related to this symptom and treatment

_____
_____

Background

Primary diagnosis and/or reason person is at the nursing home

_____
_____

Pertinent mental health history

_____
_____

Behavioral concerns identified by family

_____

Vital signs BP_____/_____ HR_____ RR _____ Temp_____
Individual is on a scheduled pain management program ___Yes ___No
If yes, what medication interventions is the individual receiving?

_____

Conditions (check all those that apply)

- ☐ orthostatic hypotension
- ☐ weight gain
- ☐ increase glucose level
- ☐ urinary retention
- ☐ constipation
- ☐ sedation
- ☐ restlessness
- ☐ pacing
- ☐ drooling
- ☐ tremors
- ☐ rigidity
- ☐ slowness of movement
- ☐ jerk body responses
- ☐
- ☐ lip smacking/ chewing/abnormal tongue movement
- ☐ involuntary movement of extremities
- ☐ worsening confusion/delirium
- ☐ fall

Other _____

Medication changes or new orders in the last two weeks _____
Recent Labs _____
Allergies _____
Any other data _____

Assessment (RN) or Appearance (LPN)

(For RNs): The individual's symptoms appear (better/worse/same) _____
I think the symptoms may be related to _____
Do you believe the individual has achieved a therapeutic dose? ___ No ___Yes If yes: Do you believe dose reduction may be needed? _____
(For LPNs): The individual's symptom(s) appear (better/worse/same) _____

Request

I suggest or request (check all that applies):

- ☐ Other (start/change non-pharmacological approach)
- ☐ Change in/stop current med order(s)
- ☐ Provider visit (MD/NP/PA)
- ☐ Continued monitoring
- ☐ Lab work

Staff name _____ **RN/LPN** _____
Reported to: Name _____ (MD/NP/PA)
Date___/___/___ **Time**____AM/PM
If to MD/NP/PA, communicated via: _____
Phone (____) ____ - _____ In-person ____

Progress Note (complete and place SBAR/progress note in medical record)

_____
_____
_____
_____
__ Family or health care proxy notified
Return call/new orders from MD/NP/PA Date___/___/___ Time___/___AM/PM

Signature_____ RN/LPN Date___/___/___ Time___/___AM

Adapted from A Toolkit for Improving Dementia Care in Nursing Homes by Quality Insights http://www.qualityinsights-qin.org.
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