SBAR FOR COVID-19

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

- Evaluate the Resident: Complete relevant aspects of the SBAR form below
- Check Vital Signs: BP, pulse, and/or apical heart rate, temperature, respiratory rate, O2 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**

Resident Name: ___________________________________ Age: ___________

Date of Admission to Facility (if within the past 30 days): __________________

Admitted From: ________________________________________________________

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

**Vital Signs**

BP: _______ Pulse: _______ (or Apical HR: _______) RR: _______ Temp: _______ Weight: _______lbs

Pulse Oximetry: _______ % on Room Air; on O2: _______ # liters of O2: _______ Blood Sugar (Diabetics): _______

**Physical Findings**

**Respiratory**

☐ Abnormal lung sounds (wheezes, rales, crackles, rhonchi)
☐ Asthma with wheezing
☐ Labored or rapid breathing
☐ SOB
☐ Capillary refill >3 sec

**Cardiovascular**

☐ Irregular pulse
☐ Chest pain
☐ Edema
☐ Cyanosis in nail beds

Has the resident had: (check all that apply)

Influenza test: ☐ COVID-19 Test: ☐ 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

☐ Other (describe): ___________________________________________________________________
**BACKGROUND**

What signs/symptoms are present: (check all that apply)

<table>
<thead>
<tr>
<th>COMMON SIGNS</th>
<th>YES</th>
<th>NO</th>
<th>UNKNOWN</th>
<th>DATE OF ONSET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever ≥ 37.2°C or 99.0°F (usual baseline temperature)</td>
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<tr>
<td>Cough (new onset or worsening of chronic)</td>
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<tr>
<td>Shortness of Breath (note: increased oxygen requirements or increased frequency of nebulizer treatments may also indicate shortness of breath)</td>
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</table>

<table>
<thead>
<tr>
<th>LESS COMMON SIGNS/SYMPTOMS</th>
<th>YES</th>
<th>NO</th>
<th>UNKNOWN</th>
<th>DATE OF ONSET</th>
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<tbody>
<tr>
<td>Runny nose/congestion</td>
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<tr>
<td>Sore throat</td>
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<tr>
<td>Chills</td>
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<td>Headache</td>
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<tr>
<td>Nausea/vomiting</td>
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<tr>
<td>Diarrhea</td>
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<tr>
<td>Headache</td>
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<tr>
<td>Fatigue</td>
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<tr>
<td>Loss of sense of taste or smell</td>
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<tr>
<td>Other:</td>
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</tbody>
</table>

14 DAYS PRIOR TO THE SYMPTOMS, DID THE RESIDENT:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>UNKNOWN</th>
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</thead>
<tbody>
<tr>
<td>Transfer from a hospital</td>
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<tr>
<td>Have community contact with anyone with lab-tested positive or suspected COVID-19 case</td>
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<tr>
<td>Have healthcare (hospital, etc.) contact with anyone with lab-tested positive or suspected COVID-19 cases</td>
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<tr>
<td>Exposure to a cluster of individuals with upper or lower respiratory disease (influenza, common cold, bronchitis, etc.)</td>
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</table>

Primary diagnosis/relevant comorbidities:

<table>
<thead>
<tr>
<th>PRE-EXISTING CONDITIONS</th>
<th>YES</th>
<th>NO</th>
<th>UNKNOWN</th>
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<tr>
<td>Chronic lung disease (emphysema, Asthma, COPD)</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Chronic renal disease</td>
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<td>Cardiovascular disease, including problems with clotting</td>
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<td>Chronic liver disease</td>
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<tr>
<td>Immunocompromised condition</td>
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<tr>
<td>Neurological, neurodevelopmental, intellectual disability</td>
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<td>Specify:</td>
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<tr>
<td>Other chronic diseases</td>
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<td>Specify:</td>
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<tr>
<td>Current smoker</td>
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<tr>
<td>Former smoker</td>
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APPEARANCE

Summarize your assessment and evaluation

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________


REVIEW & NOTIFY

Primary Care Clinician Notified: __________________________________________________________
Date: ____ / ____ / ____    Time (am/pm): _____________________
Recommendations of Primary Clinician(s) (if any):

_____________________________________________________________________________________

_____________________________________________________________________________________

☐ Transfer to the hospital (non-emergency) (send a copy of this form)
☐ Call for 911/Emergency medical transport

Name of family member notified: ________________________________ Time: ____________
DON/Administrator notified: ________________________________ Time: ____________
Medical Director notified: ________________________________ Time: ____________

If the resident develops emergency warning signs for COVID-19 get medical attention immediately.

Emergency warning signs include:
  Trouble breathing
  Persistent pain or pressure in the chest
  New confusion or inability to arouse
  Bluish lips or face
COVID-19 Symptoms: Fever, Cough, and Shortness of Breath

**PRIORITIZED FOR TESTING PATIENTS WITH SUSPECTED COVID-19 INFECTION**

**PRIORITY 1**
Ensures optimal care options for all hospitalized patients, lessen the risk of healthcare-associated infections, and maintain the integrity of the U.S. healthcare system
- Hospitalized patients
- Healthcare facility workers with symptoms

**PRIORITY 2**
Ensures those at highest risk of complication of infection are rapidly identified and appropriately triaged
- Patients in long-term care facilities with symptoms
- Patients 65 years of age and older with symptoms
- Patients with underlying conditions with symptoms
- First responders with symptoms

**PRIORITY 3**
As resources allow, test individuals in the surrounding community of rapidly increasing hospital cases to decrease community spread, and ensure health of essential workers
- Critical infrastructure workers with symptoms
- Individuals who do not meet any of the above categories with symptoms
- Healthcare facility workers and first responders
- Individuals with mild symptoms in communities experiencing high numbers of COVID-19 hospitalizations

**NON-PRIORITY**
- Individuals without symptoms

For more information visit: coronavirus.gov