

Daytime Communication Form - SBAR

Complete this form prior to calling / faxing the MRP

Use: For contacting the MRP during regular office hours (Routine & Urgent Concerns)

HAVE READY <input type="checkbox"/> COVID-19 Screening ** <input type="checkbox"/> Chart & MOST <input type="checkbox"/> Completed SBAR <input type="checkbox"/> MAR		Resident Name	
Staff Name	<input type="checkbox"/> LPN <input type="checkbox"/> RN	Call/Fax Time:	Resident DOB (DD/MM/YYYY)
Facility:	Call/Fax Date:	Resident PHN (10)	
Phone / Fax:	Local:	MRP	
		Resident's Primary Contact	

FURTHER COVID-19 SCREENING ** Common COVID-19 symptoms highlighted in red **

Other S&S's of the resident: Change in LOC; Cough or SOB; Confusion; Fatigue; Fever; Functional decline; Gastrointestinal concerns

COVID-19 Positive: Suspected Confirmed Isolation precautions No Yes: Contact / Droplet

COVID-19 Swab Collected: No Yes Infection Control aware of COVID status? N/A No Yes

COVID-19 confirmed / suspected in other resident(s): No Yes Are any facility residents utilizing AGMPs? No Yes

Any staff members showing symptoms of COVID-19? No Yes (includes: O2 >5L NP, nebulizers, BiPAP, CPAP, suctioning)

SITUATION

Reason for Call / Fax

BACKGROUND

Relevant Medical History / Usual Functional Status

Allergies

MOST: M ____ or C ____

ASSESSMENT	BP	SpO2	RR	Temp	Assessment	<input type="checkbox"/> Medication Profile Included	
	HR	eGFR	<input type="checkbox"/> Room Air <input type="checkbox"/> Oxygen @ ____ L/min				
	<i>If Available/Relevant</i>						
	INR	BG	Pain				

RECOMMEND

Nursing Recommendations

RESPONSE

Physician Response

IF RESIDENT COVID-19 + : Physician is to attend an **Emergency Outbreak Management Teleconference, 60 minutes from time of notification**, by calling **250.519.7700 ext. 26834**. Refer to the IH **COVID-19 Response Protocol: Long-term Care Facility** for further steps.