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 ☐ **COVID-19 Screening **** ☐ Completed SBAR ☐ Chart & MOST ☐ MAR		**Resident Name**
Staff Name ☐LPN ☐RN	**Call/Fax Time:**	**Resident DOB** (DD/MM/YYY) D D M M Y Y Y Y / **Resident PHN** (10)
Facility:	**Call/Fax Date:**	**MRP**
Phone / Fax:	**Local:**	**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

COVID-19 Swab Collected: ☐ No ☐ Yes

COVID-19 confirmed / suspected in other resident(s): ☐ No ☐ Yes

Any staff members showing symptoms of COVID-19? ☐ No ☐ Yes

Isolation precautions ☐ No ☐ Yes: Contact ☐ / Droplet ☐

Infection Control aware of COVID status? ☐ N/A ☐ No ☐ Yes

Are any facility residents utilizing AGMPs? ☐ 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	SpO_2	RR	Temp
HR	eGFR	☐ Room Air ☐ Oxygen @ ____ L/min	
If Available/Relevant			
INR	BG	Pain	

Assessment ☐ Medication Profile Included

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.