

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: <input type="checkbox"/> Change in LOC; <input type="checkbox"/> Cough or <input type="checkbox"/> SOB; <input type="checkbox"/> Confusion; <input type="checkbox"/> Fatigue; <input type="checkbox"/> Fever; <input type="checkbox"/> Functional decline; <input type="checkbox"/> Gastrointestinal concerns	
COVID-19 Positive: <input type="checkbox"/> Suspected <input type="checkbox"/> Confirmed COVID-19 Swab Collected: <input type="checkbox"/> No <input type="checkbox"/> Yes	Isolation precautions <input type="checkbox"/> No <input type="checkbox"/> Yes: Contact <input type="checkbox"/> Droplet <input type="checkbox"/> Infection Control aware of COVID status? <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes Are any facility residents utilizing AGMPs? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(includes: O2 >5L NP, nebulizers, BiPAP, CPAP, suctioning)</i>
COVID-19 confirmed / suspected in other resident(s): <input type="checkbox"/> No <input type="checkbox"/> Yes Any staff members showing symptoms of COVID-19? <input type="checkbox"/> No <input type="checkbox"/> Yes	

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
	<p>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.</p>

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