

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	

SITUATION	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
	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	Are any facility residents utilizing AGMPs? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(includes: O2 >5L NP, nebulizers, BiPAP, CPAP, suctioning)</i>
	Reason for Call / Fax	
	Relevant Medical History / Usual Functional Status	

BACKGROUND	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.

This fax is for authorized use by the intended recipient only. If you are not the intended recipient, you are hereby notified that any review, retransmission, conversion to hard copy, copying, circulation or any other use of this message and any attachments is strictly prohibited. If you are not the intended recipient, please notify the sender immediately and destroy this fax. (May 2020).