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| [Facility Logo] | Resident Label |

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| **S** | **Situation:** I am calling to follow-up on [resident’s name: ] who was started on antibiotic(s) recently. |
| **B** | **Background:** This patient was started on:  Antibiotic #1: Start date:  Antibiotic #2: Start date:  For: UTI Pneumonia Bronchitis Skin infection GI infection  Fever of unknown source Other, specify:  Vitals at initial presentation were as follows: BP\_\_\_\_ /\_\_\_\_ HR\_\_\_\_\_ Resp. rate\_\_\_\_\_ Temp.\_\_\_\_\_ 02 Sats.\_\_\_\_  Symptoms and positive exam findings at that time were: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  The diagnosis fits: McGeer criteria Loeb criteria Neither Assessment tool not used |
| **A** | **Assessment:**  Current vital signs: BP\_\_\_\_ /\_\_\_\_ HR\_\_\_\_\_ Resp. rate\_\_\_\_\_ Temp.\_\_\_\_\_ 02 Sats.\_\_\_\_  Since starting antibiotic(s), the resident:  now has *no* signs or symptoms of infection has remained the same  has improved but continues to have signs and symptoms of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  has *new or worsening* signs/symptoms of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Microbiology culture result (fax microbiology report if available):  has not returned yet has *no* growth was not obtained  has positive Gram stain/growth of [specify Gram stain/microorganism: ]  Is susceptible to the antibiotic(s) prescribed: Yes No Don’t know   Not tested by lab Not yet performed by lab  Other antibiotics the organism is sensitive to: |
| **R** | **Recommendation:**  Patient **is not improving** andneeds further evaluation.  Patient **has improved** andneeds final antibiotic therapy plan. |
|  | **Nurse’s Signature:** **Date/Time:**  **Faxed or Called to:** **By:** **Date/Time:** |
| **Physician Orders/Response (Please check all that apply)**  I have reviewed the above **SBAR**. | |
| Continue current antibiotic to complete a total antibiotic course of \_\_\_\_\_\_\_ days. Specify Antibiotic End date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Change antibiotic therapy to:  Drug: Dose: Route: Frequency: Duration:  Stop antibiotic now  Other (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| **Physician Signature:** | **Date/Time:** |

**Please Fax Back To:**  or **Telephone Order**

*File Under Physician Order/Progress Notes*