

SBAR Communication Tool Template for Suspected Lower Respiratory Tract Infection

[Facility Logo]

Resident Label

S	Situation I am concerned about a suspected lower respiratory tract infection (pneumonia/bronchitis) for the above patient.				
B	Background History of COPD <input type="checkbox"/> Yes <input type="checkbox"/> No Use of supplemental O ₂ <input type="checkbox"/> Yes <input type="checkbox"/> No History of heart failure <input type="checkbox"/> Yes <input type="checkbox"/> No O ₂ requirement has increased <input type="checkbox"/> Yes <input type="checkbox"/> No History of LRTI in last 6 months <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, Date: _____ Treatment: _____ Active chronic diagnosis (especially chronic lung, heart, or renal diseases, malignancies, asplenia, immunosuppression, diabetes): _____ Advance directives for limiting treatment (especially antibiotic use): _____ Medication allergies: _____				
A	Assessment Vital signs: BP ____/____ HR ____ Resp. rate ____ Temp. ____ O ₂ Sats. ____				
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; padding: 5px;"> Residents with fever ≥102°F (38.9°C) Criteria are met to initiate antibiotics if ONE of the following are selected: No Yes <input type="checkbox"/> <input type="checkbox"/> New or increased cough <input type="checkbox"/> <input type="checkbox"/> New or increased sputum production <input type="checkbox"/> <input type="checkbox"/> Respiratory rate ≥25 breaths/minute <input type="checkbox"/> <input type="checkbox"/> O₂ sat <94% on room air or >3% decrease from baseline O₂ sat <input type="checkbox"/> <input type="checkbox"/> New or changed lung exam abnormalities <input type="checkbox"/> <input type="checkbox"/> Pleuritic chest pain </td> <td style="width:50%; padding: 5px;"> Residents with fever ≥100°F (37.9°C) but <102°F (38.9°C) or ≥2.4°F (1.5°C) above baseline temperature Criteria are met to start antibiotics if BOTH of the following are selected: No Yes <input type="checkbox"/> <input type="checkbox"/> New or increased cough, <u>AND</u> <input type="checkbox"/> <input type="checkbox"/> At least one of the following: <input type="checkbox"/> Pulse >100 beats / minute <input type="checkbox"/> New or worsened delirium <input type="checkbox"/> Rigors <input type="checkbox"/> Respiratory rate ≥25 breaths/minute </td> </tr> <tr> <td style="padding: 5px;"> Afebrile resident with COPD and age >65 years old Criteria are met to initiate antibiotic if BOTH of the following are selected: No Yes <input type="checkbox"/> <input type="checkbox"/> New or increased cough, <u>AND</u> <input type="checkbox"/> <input type="checkbox"/> Purulent sputum production </td> <td style="padding: 5px;"> Afebrile resident without COPD and age >65 years old Criteria are met to initiate antibiotic if ALL of the following are selected: No Yes <input type="checkbox"/> <input type="checkbox"/> New or increased cough, <u>AND</u> <input type="checkbox"/> <input type="checkbox"/> Purulent sputum production, <u>AND</u> <input type="checkbox"/> <input type="checkbox"/> At least one of the following: <input type="checkbox"/> New or worsened delirium <input type="checkbox"/> Respiratory rate ≥25 breaths/minute </td> </tr> </table>		Residents with fever ≥102°F (38.9°C) Criteria are met to initiate antibiotics if ONE of the following are selected: No Yes <input type="checkbox"/> <input type="checkbox"/> New or increased cough <input type="checkbox"/> <input type="checkbox"/> New or increased sputum production <input type="checkbox"/> <input type="checkbox"/> Respiratory rate ≥25 breaths/minute <input type="checkbox"/> <input type="checkbox"/> O ₂ sat <94% on room air or >3% decrease from baseline O ₂ sat <input type="checkbox"/> <input type="checkbox"/> New or changed lung exam abnormalities <input type="checkbox"/> <input type="checkbox"/> Pleuritic chest pain	Residents with fever ≥100°F (37.9°C) but <102°F (38.9°C) or ≥2.4°F (1.5°C) above baseline temperature Criteria are met to start antibiotics if BOTH of the following are selected: No Yes <input type="checkbox"/> <input type="checkbox"/> New or increased cough, <u>AND</u> <input type="checkbox"/> <input type="checkbox"/> At least one of the following: <input type="checkbox"/> Pulse >100 beats / minute <input type="checkbox"/> New or worsened delirium <input type="checkbox"/> Rigors <input type="checkbox"/> Respiratory rate ≥25 breaths/minute	Afebrile resident with COPD and age >65 years old Criteria are met to initiate antibiotic if BOTH of the following are selected: No Yes <input type="checkbox"/> <input type="checkbox"/> New or increased cough, <u>AND</u> <input type="checkbox"/> <input type="checkbox"/> Purulent sputum production	Afebrile resident without COPD and age >65 years old Criteria are met to initiate antibiotic if ALL of the following are selected: No Yes <input type="checkbox"/> <input type="checkbox"/> New or increased cough, <u>AND</u> <input type="checkbox"/> <input type="checkbox"/> Purulent sputum production, <u>AND</u> <input type="checkbox"/> <input type="checkbox"/> At least one of the following: <input type="checkbox"/> New or worsened delirium <input type="checkbox"/> Respiratory rate ≥25 breaths/minute
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R	Recommendations <input type="checkbox"/> Protocol criteria met. Resident may require a chest X-ray, CBC with differential, and/or antibiotics. <input type="checkbox"/> Protocol criteria NOT met. Resident does not need immediate antibiotic order but may need additional observation.				
Nurse's Signature: _____ Date: _____ <input type="checkbox"/> Notification of Family/POA Name: _____ Date/Time: _____ <input type="checkbox"/> Faxed or <input type="checkbox"/> Called to: _____ By: _____ Time: _____					

Physician Orders/Response (Please check all that apply)

I have reviewed the above SBAR.

<input type="checkbox"/> Chest X-Ray <input type="checkbox"/> For cough, use cough suppressant: _____ Dose: _____ Route: _____ Frequency: _____ Duration: _____. <input type="checkbox"/> For fever, use acetaminophen. Dose: _____ Route: _____ Frequency: _____ Duration: _____. <input type="checkbox"/> For shortness of breath, inhale/nebulize: _____ Dose: _____ Route: _____ Frequency: _____ Duration: _____. <input type="checkbox"/> Encourage 4 oz. of fluid (_____) TID, until symptoms resolve. <input type="checkbox"/> Record fluid intake & output until symptoms resolve (output can also be measured from urinal or by weighing briefs, etc.). <input type="checkbox"/> Assess vital signs, including temp, every ____ hours for ____ hours; notify PCP if symptoms worsened or unresolved in ____ hours. <input type="checkbox"/> Other orders: _____ <input type="checkbox"/> For antibiotic orders (if needed) please complete script
Drug: _____ Dose: _____ Route: _____ Frequency: _____ Duration: _____ Indication: _____

Physician Signature	Date
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Please Fax Back To: _____

Telephone Order

File Under Physician Order/Progress Notes

