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| [Facility Logo] | Resident Label |

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| **S** | **Situation**I am concerned about a suspected cellulitis / soft-tissue infection / wound infection for the above patient. |
| **B** | **Background**History of recurrent skin infections [ ]  Yes [ ]  No History of diabetes[ ]  Yes [ ]  No History of peripheral vascular disease [ ]  Yes [ ]  No History of chronic ulcer [ ]  Yes [ ]  NoActive chronic diagnosis (especially chronic lung, heart, or renal diseases, malignancies, asplenia, immunosuppression, diabetes):  Is the resident on warfarin (Coumadin®) [ ]  Yes [ ]  NoAdvance directives for limiting treatment (especially antibiotic use): Medication allergies:   |
| **A** | **Assessment**Vital signs: BP / HR Resp. rate Temp. O2 Sats.. ..

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| **Minimum criteria to initiate antibiotics are met if ONE of the following 2 scenarios are selected:**No Yes[ ]  [ ]  New or increasing purulent drainage at a wound, skin, or soft-tissue site[ ]  [ ]  At least 2 of the following new or worsening signs or symptoms: [ ]  More heat (warmth) at affected site relative to other areas of the body [ ]  Redness (erythema) at affected site [ ]  Swelling at affected site [ ]  Increased tenderness or pain at affected site [ ]  Fever of 100°F (38°C), repeated temp of 99°F (37°C), or temp of 2°F (1°C) above baseline  | **Additional description of affected site:****Location**[ ]  Left side [ ]  Right side [ ]  Multiple sites**Body site**[ ]  Face/head/neck [ ]  Upper extremities [ ]  Chest/abdomen [ ]  Groin [ ]  Back [ ]  Buttock [ ]  Lower extremities [ ]  Others: **Depth**[ ]  Intact skin [ ]  Superficial wound [ ]  Deep wound**Drainage**[ ]  None [ ]  Serous [ ]  Serosanguinous[ ]  Purulent**Other significant findings:**    |

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| **R** | **Recommendations**[ ]  **Protocol criteria met.** Resident may require antibiotics with or without wound care.[ ]  **Protocol criteria NOT met.** Resident **does not** need immediate antibiotic order but may need additional observation. |
|  | **Nurse’s Signature:** **Date:** [ ]  **Notification of Family/POA Name:** **Date/Time:** [ ]  **Faxed or** [ ]  **Called to:** **By:** **Time:**  |
| **Physician Orders/Response (Please check all that apply)**[ ]  I have reviewed the above **SBAR**. |
| [ ]  For wound care, apply OR [ ]  Consult wound care team[ ]  For fever / pain relief, use [Drug: Dose: Route: Frequency: Duration: ] [ ]  Encourage \_\_\_\_\_\_\_\_\_\_\_\_ ounces of fluid intake \_\_\_\_\_\_\_\_\_ times daily, until fever / symptoms resolve.[ ]  Record fluid intake & output until symptoms resolve (output can also be measured from urinal or by weighing briefs, etc.).[ ]  Assess vital signs, including temp, every hours for hours; notify PCP if symptoms worsened or unresolved in hours. [ ]  Other orders: [ ]  For antibiotic orders (if needed) please complete scriptDrug: Dose: Route: Frequency: Duration: Indication: Additional Drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Physician Signature | Date |

**Please Fax Back To:** [ ]  **Telephone Order**

**File Under Physician Order/Progress Notes**