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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  No  Active chronic diagnosis (especially chronic lung, heart, or renal diseases, malignancies, asplenia, immunosuppression, diabetes):    Is the resident on warfarin (Coumadin®)  Yes  No  Advance directives for limiting treatment (especially antibiotic use):  Medication allergies: |
| **A** | **Assessment**  Vital signs: BP / HR Resp. rate Temp. O2 Sats.. ..   |  |  | | --- | --- | | **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:** | |
| **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 script  Drug: 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**