Script: Report to Physician using SBAR

All telephone calls to physicians are more effective when information is presented in a clear, concise format. Using the SBAR (Situation-Background-Assessment-Recommendation) outline benefits residents through effective telephone communication between nurses and physicians.

**Before Calling the Physician**, ask:
- Is my assessment current? Am I calling the correct doctor for this problem?
- What is the code status/POLST/Intensity of Care on this patient?
- Is the chart & Medication Record (MAR) here for when the physician returns my call?
- To keep your message focused and concise, you may want to write down:
  - Patient/resident’s name, age, admitting diagnosis, allergies
  - The problem is _______ and specific symptoms, vital signs, etc.

**Situation**: State the situation, issue or problem that is happening.
- I am ____________ (RN, LVN) from ____________ (Hospital/SNF/Hospice).
- I am calling about ____________ a patient of Dr. ____________.
- The problem is: ____________.
  - Be concise; clearly state important details. For example: *Today or in the last ___ hours, Mrs. Lee has had severe pain not relieved by current order of one Vicodin 5/325 or has vomited X 2 and her BP is 186/108.*

**Background**: Give the pertinent history or background to the event that you are reporting.
- The admitting diagnosis is: ____________ and she was admitted on: ____________.
- State pertinent medical history: ____________.
  - For example: She was admitted with CVA and has been stable or was discharged from the hospital ___ days ago or she is a long-term patient, and POLST is comfort measures only, No CPR, and family is aware of her current status.
- Briefly describe current treatment of the problem: ____________.
  - For example: Her BP was low last week and Metoprolol was stopped.

**Assessment**: State appropriate assessment facts and know time of last assessment.
- Her BP is: _____, Pulse ____, Respirations ____, Temperature ____ Pain level _____.
- Pulse Oximetry is: ____%. If on Oxygen: She is on ____ Liters/minute of oxygen.
- Pertinent physical exam findings: ____________. Fingerstick Glucose is: ___.
- Describe any changes from past assessment or new problems: ____________.
  - For example: change in mental status, skin color, pulse or respiratory rate/quality, recent abnormal lab values, poor intake, other new symptoms, like vomiting, diarrhea, headache, agitation, confusion.
- Her POLST or PIC completed on: ________ is: ____ (CPR or Do Not Attempt CPR); and
  - Medical Interventions are: ____________.

**Recommendations**: Be prepared to state what you think needs to happen to resolve this problem.
- I think she would benefit from: ____________.
  - For example: Increasing her Vicodin to 5/325 two tablets qid prn pain 7 to 10 or transfer to hospital for evaluation and treatment or xray of left foot, which we can do portable at our facility.
- Clarify details of orders or any change in treatment.
  - For example: Frequency of Vital Signs or Blood Sugar testing or parameters to call physician:
    Shall we call if systolic BP greater than 160? or I will notify Dr. Reynolds, her PCP, tomorrow.
  - Insist on a verbal read back of any new orders received as a Telephone Order.