

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: _____. Fingertstick 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 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.*