# Suspected UTI SBAR

Complete this form before contacting the resident's physician.

Date/Time _____

Nursing Home Name _____

Resident Name _____ Date of Birth _____

Physician/NP/PA _____ Phone _____

Fax _____

Nurse _____ Facility Phone _____

Submitted by ☐ Phone ☐ Fax ☐ In Person ☐ Other _____

## S Situation

I am contacting you about a suspected UTI for the above resident.

Vital Signs BP _____ /_____ HR _____ Resp. rate _____ Temp. _____

## B Background

Active diagnoses or other symptoms (especially, bladder, kidney/genitourinary conditions)

Specify _____

☐ No ☐ Yes The resident has an indwelling catheter

☐ No ☐ Yes Patient is on dialysis

☐ No ☐ Yes The resident is incontinent If yes, new/worsening? ☐ No ☐ Yes

☐ No ☐ Yes Advance directives for limiting treatment related to antibiotics and/or hospitalizations

Specify _____

_____

☐ No ☐ Yes Medication Allergies

Specify _____

_____

☐ No ☐ Yes The resident is on Warfarin (Coumadin®)

Nursing Home Name _____ Facility Fax _____

Resident Name _____

## A Assessment Input (check all boxes that apply)

**R . WITH . a**

The criteria are met to initiate antibiotics if one of the below are selected

**N Y .**

- ☐ ☐ Fever of 100°F (38°C) or repeated temperatures of 99°F (37°C)*
- ☐ ☐ New back or ank pain
- ☐ ☐ Acute pain
- ☐ ☐ Rigors /shaking chills
- ☐ ☐ New dramatic change in9082 T703>lyc08.9082 Tm ( )241 TeRs2_0 1 Tf 9.5 0 .5 0 0 9.5 81.4656 594.904