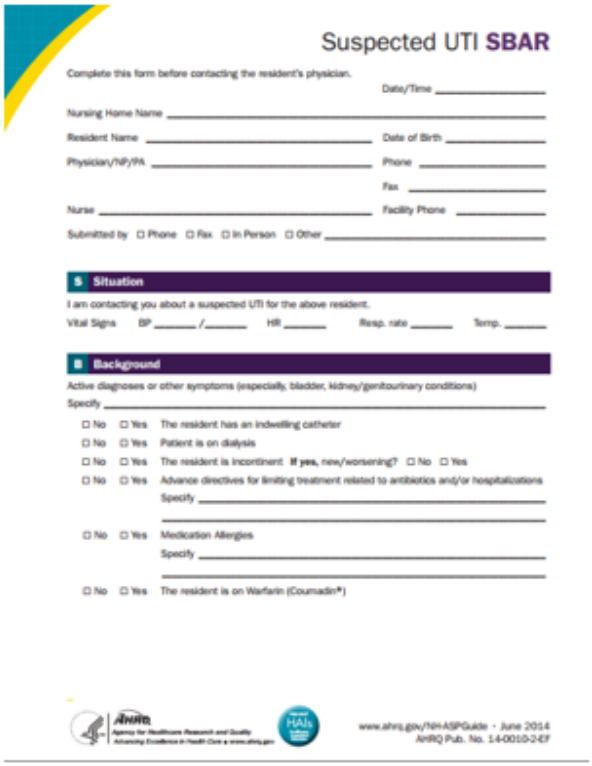
Tools for Nurses to Evaluate and Communicate Infection Criteria:

Option 1: Utilize the AHRQ Tools for Infection Criteria
https://www.ahrq.gov/nhguide/toolkits/determine-whether-to-treat/index.html



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®)

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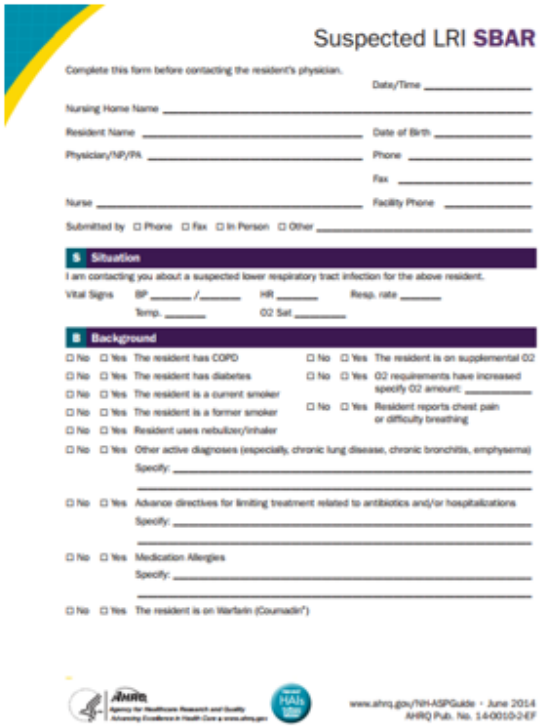

Suspected LRI **SBAR**

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 lower respiratory tract infection for the above resident.

Vital Signs BP _____ / _____ HR _____ Resp. rate _____
Temp. _____ O2 Sat _____

B Background

☐ No ☐ Yes The resident has COPD
☐ No ☐ Yes The resident has diabetes
☐ No ☐ Yes The resident is a current smoker
☐ No ☐ Yes The resident is a former smoker
☐ No ☐ Yes Resident uses nebulizer/inhaler
☐ No ☐ Yes The resident is on supplemental O2
☐ No ☐ Yes O2 requirements have increased
specify O2 amount: _____
☐ No ☐ Yes Resident reports chest pain or difficulty breathing

☐ No ☐ Yes Other active diagnoses (especially, chronic lung disease, chronic bronchitis, emphysema)
Specify: _____

☐ 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®)

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