# 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)

**Resident WITH indwelling catheter**

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

| No | Yes | |
|---|---|---|
| ☐ | ☐ | Fever of 100°F (38°C) or repeated temperatures of 99°F (37°C)* |
| ☐ | ☐ | New back or flank pain |
| ☐ | ☐ | Acute pain |
| ☐ | ☐ | Rigors /shaking chills |
| ☐ | ☐ | New dramatic change in mental status |
| ☐ | ☐ | Hypotension (significant change from baseline BP or a systolic BP <90) |

**Resident WITHOUT indwelling catheter**

Criteria are met if one of the three situations are met

| No | Yes | |
|---|---|---|
| ☐ | ☐ | 1. Acute dysuria alone |

**OR**

| | | |
|---|---|---|
| ☐ | ☐ | 2. Single temperature of 100°F (38°C) **and** at least one new or worsening of the following: |

- ☐ urgency
- ☐ frequency
- ☐ back or flank pain
- ☐ suprapubic pain
- ☐ gross hematuria
- ☐ urinary incontinence

**OR**

| | | |
|---|---|---|
| ☐ | ☐ | 3. No fever, but two or more of the following symptoms: |

- ☐ urgency
- ☐ frequency
- ☐ incontinence
- ☐ suprapubic pain
- ☐ gross hematuria

**Nurses:** Please check box to indicate whether or not criteria are met

☐ **Nursing home protocol criteria are met.** Resident may require UA with C&S or an antibiotic.†

☐ **Nursing home protocol criteria are NOT met.** The resident does NOT need an immediate prescription for an antibiotic, but may need additional observation.††

## R Request for Physician/NP/PA Orders

Orders were provided by clinician through ☐ Phone ☐ Fax ☐ In Person ☐ Other _____

☐ Order UA

☐ Urine culture

☐ Encourage _____ ounces of liquid intake _____ times daily until urine is light yellow in color.

☐ Record fluid intake.

☐ Assess vital signs for _____ days, including temp, every _____ hours for _____ hours.

☐ Notify Physician/NP/PA if symptoms worsen or if unresolved in _____ hours.

☐ Initiate the following antibiotic

Antibiotic: _____ Dose: _____ Route: _____ Duration: _____

☐ No ☐ Yes Pharmacist to adjust for renal function

☐ Other _____

**Physician/NP/PA signature** _____ Date/Time _____

Telephone order received by _____ Date/Time _____

Family/POA notified (name) _____ Date/Time _____

* For residents that regularly run a lower temperature, use a temperature of 2°F (1°C) above the baseline as a definition of a fever.

† This is according to our understanding of best practices and our facility protocols. Minimum criteria for a UTI must meet 1 of 3 criteria listed in box.

†† This is according to our understanding of best practices and our facility protocols. The information is insufficient to indicate an active UTI infection.