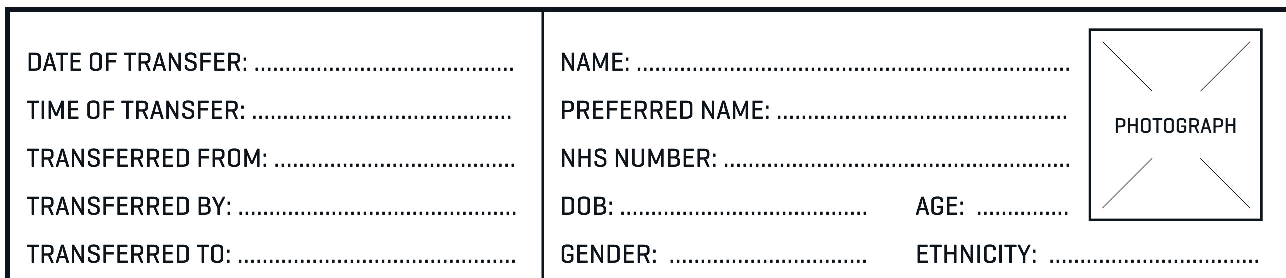
Red Bag - Resident Assessment Form & SBAR

Right care, right time, right place

ADDITIONAL PAPERWORK INCLUDED: *YES / NO* [PLEASE ATTACH SECURELY]



DATE OF TRANSFER: ....
TIME OF TRANSFER: ....
TRANSFERRED FROM: ....
TRANSFERRED BY: ....
TRANSFERRED TO: ....

NAME: ....
PREFERRED NAME: ....
NHS NUMBER: ....
DOB: .... AGE: ....
GENDER: .... ETHNICITY: ....

PHOTOGRAPH

PATIENT'S ADDRESS: ....
....
....
TEL NUMBER: ....
TEMPORARY / PERMANENT [PLEASE CIRCLE]
IF TEMP - USUAL ADDRESS + TEL: ....
....
REGISTERED CARE CATEGORY [PLEASE CIRCLE]:
GEN NURS - EMI NURS - RES - EMI RES
GP NAME: ....
SURGERY: ....
TEL NO: ....
PHARMACY: ....
TEL NO: ....
TEMPORARY / PERMANENT [PLEASE CIRCLE]
IF TEMP - USUAL GP: ....
INFORMED: *YES / NO* DNAR: *YES / NO*

1ST LANGUAGE: ....
RELIGION: .... PRACTICING / NON PRACTICING
CHC FUNDED: *YES / NO* CHC CHECKLIST COMPLETED: DATE SENT: ....
CHC FAST TRACK COMPLETED: DATE SENT: ....
NOK NAME: ....
NOK ADDRESS: ....
....
....
....
NOK TEL NO: ....
NOK: *INFORMED / NOT INFORMED* [OF HOSPITAL ADMISSION]
DOLS IN PLACE IN CARE HOME ☐
DNR: *YES / NO*

SBAR [SITUATION BACKGROUND ASSESSMENT RECOMMENDATION]

SITUATION

YOUR NAME & ROLE
....
WHAT IS THE CONCERN REGARDING THE RESIDENT? [BRIEFLY]
....

BACKGROUND

PAST MEDICAL HISTORY / DIAGNOSIS
....
RESIDENT'S NORMAL CONDITION
....

RESPECT FORM? *YES / NO*	DNAR? *YES / NO*	ADVANCED CARE PLAN? *YES / NO*

ASSESSMENT

HOW HAS THE RESIDENT CHANGED FROM THEIR USUAL SELF?
....
KEY OBSERVATIONS
....

RECOMMENDATION

THE PROBLEM MAY BE ....

EXAMINATION & OBSERVATIONS

COGNITION:

IS THE PERSON LIVING WITH DEMENTIA? YES / NO
IS THE PERSON MORE CONFUSED / AGITATED THAN NORMAL? YES / NO

	BASELINE	CURRENT	DATE/TIME
BLOOD PRESSURE:	....	....	....
TEMPERATURE:	....	....	....
PULSE:	....	....	....
RESPIRATORY RATE:	....	....	....
O2 SATS:	....	....	....
BLOOD SUGAR:	....	....	....

RESIDENTS USUAL SELF	BASELINE / USUAL	ON ADMISSION (NOW)	COMMENTS
*REFER TO FUNCTIONAL TIPS **MOBILITY** TRANSFERS/AIDS/FALLS			
PERSONAL CARE WASHING/ DRESSING			
SKIN INTEGRITY PRESSURE AREAS/WOUNDS			
ELIMINATION URINARY/BOWEL/CATHETER/STOMACH			
COMMUNICATION SPEECH/HEARING/VISION			
MENTAL HEALTH COGNITION/ORIENTATION/MOOD			
NUTRITION FOOD/FLUIDS/SWALLOWING	WEIGHT ON TRANSFER:		
LEVEL OF CONSCIOUSNESS: ALERT / DROWSY / NOT RESPONDING TO CALL			

NOTES / ANY OTHER COMMENTS

NAME OF PERSON COMPLETING: ....

ROLE / DESIGNATION: ....

CONTACT NUMBER: ....

KEY CONTACT: ....
FOR EXCHANGE OF INFO DURING HOSPITAL STAY

SIGNED: ....

TIME: ....

DATE: ....

* ENSURE A COPY OF THIS FORM IS PLACED IN THE CARE HOME NURSING NOTES *