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| **Clinical SBAR REPORT Template****Situation/Background/Assessment/Recommendations** |
| **S** | **Pt. Initials: Age: Rm# Admit date:****MD (primary & consults):****Admission/Primary Dx:****Pt Changes or Pt Stable** |
| **B** | **Allergies:** **Code Status: Isolation: Restraints: Other Precautions:****Medical Hx/Chronic Dx** **Surgeries/Procedures:****Family Situation:** |
| **A** | **VS**:**Neuro:**Pain w/locationAAO x3MoodSpeech patternHearing (aid)Glasses/BlindNeurocheck**CV:**Abn findingsTelePacer**Resp:**Abn findings02/LInc. Spir.**Endocrine:**Acc **√** : time: BS: Coverage: time: BS: Coverage:  | **Musculo/Skeletal**Activity/assist x\_Ambulatory Aids**GI:**Diet/ToleranceFeeding TubeAspiration/Swallowing PrecautionsDenturesLast BM**GU:**I/OFoley**Skin:**DrainsWd/Pres. UlcersBraden Scale**IV Access & Fluids:** |
| **R** | **Plan for Shift:** ADLs: C/P/S **Daily Wgt**:Treatments:Time for PT/Tests off Unit:Estimated Date of D/C or Transfer**Teaching/Learning/Special Needs** |
| **Labs:**  **Other Diagnostics:** |
| **Medications:** | **Dose** | **Route** | **Indication** | **Time** |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| 4. |  |  |  |  |
| 5. |  |  |  |  |
| 6. |  |  |  |  |