|  |  |
| --- | --- |
| S | **(S) Situation:*** Patient’s name/Age/Room
* Admission Date
* Admission diagnosis /Current diagnosis
* Pt Changes/Issue (the reason for the report)
 |
| B | **(B) Background:*** Pertinent Medical/Surgical History (PMH/PSH))
* Medication highlights/changes
* Code Status
* Allergies / Sensitivities
* Special Precautions: Isolation, Falls……,
* Special Needs: Hearing impaired, Safety issues
* Pertinent family situation
 |
| A | 1. **Assessment:**

 Systems Review (**Abnormal**)* Vital Signs: BP HR RR Temp
* Neurological: Orientation Status
* Respiratory: $O\_{2}$, Pulse Ox
* Gastro-intestinal: Diet, NPO, N/ V/ D
* Vascular: Color changes
* Cardiac / Telemetry: Rhythm changes
* Endocrine: Accu – Checks, Insulin
* Skin Breakdown: Incisions – location, drainage
* GU: Foley , I & O
* Pain: Pain scale
* Musculoskeletal: weakness, activity

Current Treatments:* Pain: Controlled with….
* IV / lines: Type, issues
* I & O Weight

Testing: Today /Tomorrow / Future* Bloodwork
* Radiology
* Other
* Pending / Medications due
 |
| R |  **(R)** **Recommendations:**The Plan of Care is: Desired end state is:Outstanding issues that must be addressed are:Examples: H & H due at 0200, bowel prep, Confirmation of PICC line placement, Needs flu vaccine at discharge, parents are coming in to sign consent form, etc.Contact method: Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**“To be clear, we are going to…..”** |