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| 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: , 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…..”** |