SBAR Nursing Handoff

SBAR Nursing Handoff

I. Situation

Patient Name:

Room Number:

Brief Description of Current Situation:

Chief Complaint/Reason for Admission:

Blood Pressure:

Heart Rate:

Respiratory Rate:

Temperature:

Oxygen Saturation:

II. Background

Admitting Diagnosis:

Allergies:

Current Medications (including IV medications and rates):

CBC:

BMP:

Coagulation Profile:

X-rays:

CT scans:

MRIs:

Relevant Procedures/Interventions:

Current Code Status:

Family Support/Concerns:

Advanced Directives:

III. Assessment

Level of Consciousness (LOC):

Pain Level:

Mobility:

Skin Integrity:

Respiratory Status:

Cardiovascular Status:

Gastrointestinal Status:

Neurological Status:

Any Changes Since Last Shift:

Concerns/Issues:

Nursing Interventions:

Pending Consultations:

Scheduled Procedures:

Response to Interventions:

Anticipated Changes:

IV. Recommendation

Specific Actions Needed:

Plan for the Next Few Hours:

Escalation Plan:

Patient and Family Education Needs:

V. Additional Information

Patient Preferences:

Pending Tasks:

Any Unresolved Issues:

Verification

Read-back from the receiver:

Any questions or clarifications:

Follow-up

Scheduled Follow-up Handoff:

Documented Communication: