SBAR-Clinical: Acute Care

Addressograph

The written SBAR Clinical supports communicating and highlighting a summary of pertinent information, to guide ongoing quality care for referral, consultation or mitigating risk during care transition.

Situation: *Reason for transfer/consult/referral*; **What are the patient concerns that have resulted in this need?**

Date: ___________________________ Transfer/Consult/Referral to: ____

Diagnosis:

Background: *Relevant medical and psychosocial history*

Allergies: ☐ Yes ☐ No List: _______________________________________ Reaction ______________________________

ACP status: ☐ ACP-R ☐ ACP-M ☐ ACP-C ARO: ☐ Yes ☐ No Isolation: ☐ Yes ☐ No

Hx:

Assessment: *Summarize pertinent and significant findings and your assessment. What do you think the problem is? What are you worried about? What is your gut sense?*

CNS:

Resp:

CVS:

GI/GU:

Musc-Skeletal/SCHIPP/Transfer:

Skin:

Psych/Soc:

Abnormal Diagnostics:

VS trends:

Pain:

Other:

Impression: What is the Problem?

Recommendation(s): *What do you recommend for immediate care needs? Share your insight regarding what to worry about, what could go wrong and what to look for? Confirm shared understanding with receiving provider*

Plan/Goals of care:

☐ Valuables sent with patient ☐ Valuables received with patient

Documenting SBAR-Clinical is Optional (may be used to guide standardized verbal communication)

Date: ____ Time: ____________________________________

Information shared ____

Completed by: ______________________________________ Signature: ____________________________

Documented SBAR/copy is filed in the Patient Health Record