SBAR Clinical Home Care

Client's Name _____
PHIN _____ Date of birth_____
VPP alert: _____ Yes _____ No
Primary Care Provider: _____
Primary Contact Person:_____

☐ Health Care Provider_____ FAX:_____ Phone:_____

☐ Skin & Wound Care Coordinator _____ Fax: _____ Phone: _____
(Include Skin and Wound Care Coordinators for clients with wounds seen at Portage Clinic and Steinbach Family Medical Clinic).

Return Completed Document To:_____ FAX:_____ PHONE:_____

Situation: *Reason for transfer/consult/referral*

Background: *Relevant medical and psychosocial history*

Allergies:

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

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*

Date: _____ Time: _____

Completed by: _____ Signature: _____

Documented SBAR is filed in the Client Health Record

Health Care Provider Response/Orders

Signature: _____ Date: _____