Name: _____ Room #: _____

Age: ____ y/o M / F Hospitalists / Trauma / ___

DNI /FULL CODE / DNR

S Situation	*What is happening?* *When did this happen?* *Where did this happen?* *Ex: (patient initial) is (age) (gender) transferred from (facility) and admitted (insert date) to be treated for (insert Primary diagnosis)*
B Background	**PMH:** DM / CHF / HTN / CAD / PCI / HLD / PVD / GERD / COPD / Asthma / CKD / ESRD / Smoker / Drug Abuse / Psych / CVA / Dementia / Hypothyroid / CA / (Insert Secondary Diagnosis)
	Tests: MRI / X-Ray / CT / Echo EF: ____ / Endo / US / Cath *Helpful to mention timelines. Ex: Patient had an X-ray done on June 22nd which showed a fracture to left radial head* Admit DATE: _____

A Assessment

Contact: MRSA, C-Diff, ESBL, Flu, Droplet, Neutropenic

Need: Urine Cx, Resp Cx, Flu Swab, MRSA Swab

Extras: Daily Weight, Strict I&Os, Fall Risk, Observation, 1:1 Sitter, NPO @ Midnight

IV: #_____ R / L SL **Date:** _____
Site: AC / FA / Hand / Wrist / UA
Central: IJ / PICC / Port / Trialysis

IVF: NS / ½ NS / D5 ½ / D5 NS / LR / Abx
IV Rate: _____ ml/hr / _____ u/kg/hr
Drips: Heparin / Blood / TPN / Dilt
Any Antibiotics?
Ex: Pt is currently receiving IV Vancomycin Q6 next lab draw

Neuro
A & O x ___ / Confused
Activity: Up ad lib / 1 / 2 / Bed-rest
Walker / Cane
Neuro Checks / Restraints / Bed Alarm
PERRLA (pupils equal round and reactive to light and accommodation)

Left Pupil ___brisk ___ sluggish. ___ size
Right Pupil. Brisk ___ sluggish. ___size

Pain
Level:
Location:
Medication:
Frequency:

Respiratory (where did you hear these sounds) LLL LUL RLL RUL
O2 @ ___L NC / Room air / NRB / CPAP / BIPAP / **Trach:** _____
Breath Sounds: Clear / Diminished / Wheezing / Crackles / Coarse/ Rales
Treatments: Nebs / IS / CPT **Cough:** Productive / Non-productive

VS Trend
HR Temp
BP RR
O_2

Cardiovascular
SB / NSR / ST / A-Fib / A-Flutter / A-Paced / V-Paced / PACs / PVCs
AICD / Murmur / Block
Edema: None / Gen / Trace / 1+ / 2+ / 3+
Pitting / Non-pitting R / L / Bilateral Arms / Legs
Pulses: DP Radial Dopplers / +1 / +2

VTE Prophylaxis
SCDs / Foot Pumps
Heparin / Lovenox
Coumadin / Xarelto
Eliquis / None Needed
Needs Order

Gastrointestinal
Diet: Reg / Clear / Full / AHA / ADA / Dysphagia I II III
Soft / Renal / NPO
Hypo / Normoactive / Hyper / Nausea / Vomiting /

Genitourinary
Voiding / Foley / Incontinence / Anuria
Clear / Cloudy Yellow / Amber / Bloody (
BR / Urinal / Bedside Comm / Bedpan

	Diarrhea G-tube (LWS / Gravity) / Ostomy ***Last BM:*** _____	Dialysis: M Tu W Th F Sa Su ESRD: Anuretic/Voids
	Musculoskeletal Weakness: RUE / LUE / RLE / LLE Numbness: RUE / LUE / RLE / LLE	**Skin** (Wounds & Dressings) W/D/I (Warm, Dry, Intact)/Pale/Flushed/Cyanotic/Jaundiced/ Pale/ Flushed/Cyanotic/Jaundice/Diaphoretic Skin is Cool to touch/Warm to touch/ Tenting (↓ turgor)/ Petechiae/Ecchymosis (bruising)/Rash/ Dry / Scaly/ Clammy/ Intact / Non-intact/ Edematous/ Fragile / Thin/Mottled/ Skin tone even / Uneven
	BG Monitoring AC&HS / Q6° / Q___° **AC B** **AC L** **AC D** **HS** **Drains** Chest Tube / JP / Hemovac / Accordion / Wound Vac (R / L) Level: _____ Serosanguinous / Sanguineous	**Labs (date)** WBC K CKMB Hgb INR BNP Na Anti-Xa Trop Plt Cr Lipase NH_3 LFTs
	Medications:What is the patient taking and why **Example:** *She is currently taking Apixaban 2.5 mg PO Q12H for A-fib and Metoprolol 25 mg PO BID for hypertension.*	
R Recommendation	***(****Always use a reference here for your recommendation. Why did you make that recommendation and what resource did you use to support why.* ***Ex:*** *I also recommend consulting with a social worker regarding her concern about going home. Social workers help with coordinating client discharge and their continuity of care planning (Potter, Perry, Stockert, & Hall, 2017). Additional education should also be provided, on how to properly use her front wheel walker.* **Scheduled Procedures:** Cath / US / Stress / Echo / Dopplers / MRI **Consults:** CM / PT / OT / GI / Cards / Neuro / Nephro / Wound / Ortho / Psych / Pulm / Surg **Discharge to:** Home / Home Health / ALF / SNF / Rehab	

Description is key. Although not every SBAR will require this. If your patient has a wound, you should always chart it. This is why your skin assessment is so important. Did they come to the hospital with it, or is it a new onset? A new wound could indicate worsening symptoms. (ex: Kennedy Wound only found in hospice patients, which indicates terminal illness)

1. Location
Clearly describe where the wound is using body landmarks (e.g., "left ankle, inner side" or "lower back/sacrum"). A body diagram can help.

2. Type of Wound
Say what kind it is: scrape (abrasion), cut (laceration), pressure injury (include the stage), or surgical wound.

3. Size
Measure the wound:

- **Length:** head to toe
- **Width:** side to side
- **Depth:** if needed
- If there's tunneling or undermining, describe the depth and direction (like a clock: "2 o'clock, 2 cm deep").

4. Tissue Inside the Wound
Describe what the wound bed looks like:

- **Healthy tissue:** red/pink and moist (granulation)
- **Dead tissue:** yellow/brown (slough) or black (necrosis)
- Estimate how much of each is there in percentages.

5. Drainage (Fluid from Wound

- **Amount:** none, light, moderate, heavy
- **Color:** clear (serous), bloody (sanguineous), pus (purulent)
- **Thickness:** watery or thick
- **Odor:** if it smells unusual, mention it

6. Skin Around the Wound (Periwound)
Check for:

- Redness, swelling, firmness, softness, moisture damage
- Describe the edges: smooth, rolled, or hard/calloused

7. Pain
Ask about pain:

- Use a pain scale (0–10)
- Note where the pain is, how bad, and what makes it better or worse

8. Extra Info
Include:

- **Cause of the wound:** (e.g., poor circulation, pressure)
- **Healing signs:** like new skin forming
- **Treatment progress:** is it healing, getting worse, or staying the same?
- **Dressing:** what kind is used, and if it was changed