SBAR Nursing Handoff

I. Situation
Patient Name:
Room Number:
Brief Description of Current Situation:
Chief Complaint/Reason for Admission:
Vital Signs (current): • Blood Pressure: • Heart Rate: • Respiratory Rate: • Temperature: • Oxygen Saturation:

II. Background
Admitting Diagnosis:
Allergies:
Current Medications (including IV medications and rates):
Recent Lab Results: • CBC: • BMP: • Coagulation Profile:

Recent Imaging Results:

- X-rays:
- CT scans:
- MRIs:

Relevant Procedures/Interventions:

Current Code Status:

Family Support/Concerns:

Advanced Directives:

III. Assessment

Current Patient Status:

- Level of Consciousness (LOC):
- Pain Level:
- Mobility:
- Skin Integrity:
- Respiratory Status:
- Cardiovascular Status:
- Gastrointestinal Status:
- Neurological Status:

Any Changes Since Last Shift:

Concerns/Issues:

Plan of Care

- 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: