SBAR Template

Patient Information	
Name	**Age**
Gender	**Date of birth**
Chief complaint	

Situation

Briefly describe the patient's condition, including relevant medical history, chief complaint, vital signs, and any significant changes or concerns.

Background

Provide a concise overview of the patient's current status, previous medical/surgical history, medications, allergies, and relevant laboratory results or diagnostic findings.

Assessment
Summarize your assessment of the patient's condition, including your observations, physical examination findings, and any changes or deterioration you've noted.
Recommendation
Offer your professional recommendations based on the situation and assessment. This may include specific interventions, treatment options, or necessary consultations. Also, indicate the urgency level and any immediate actions required.
Additional notes

Attending nurse	**Date and time**	**Signature**