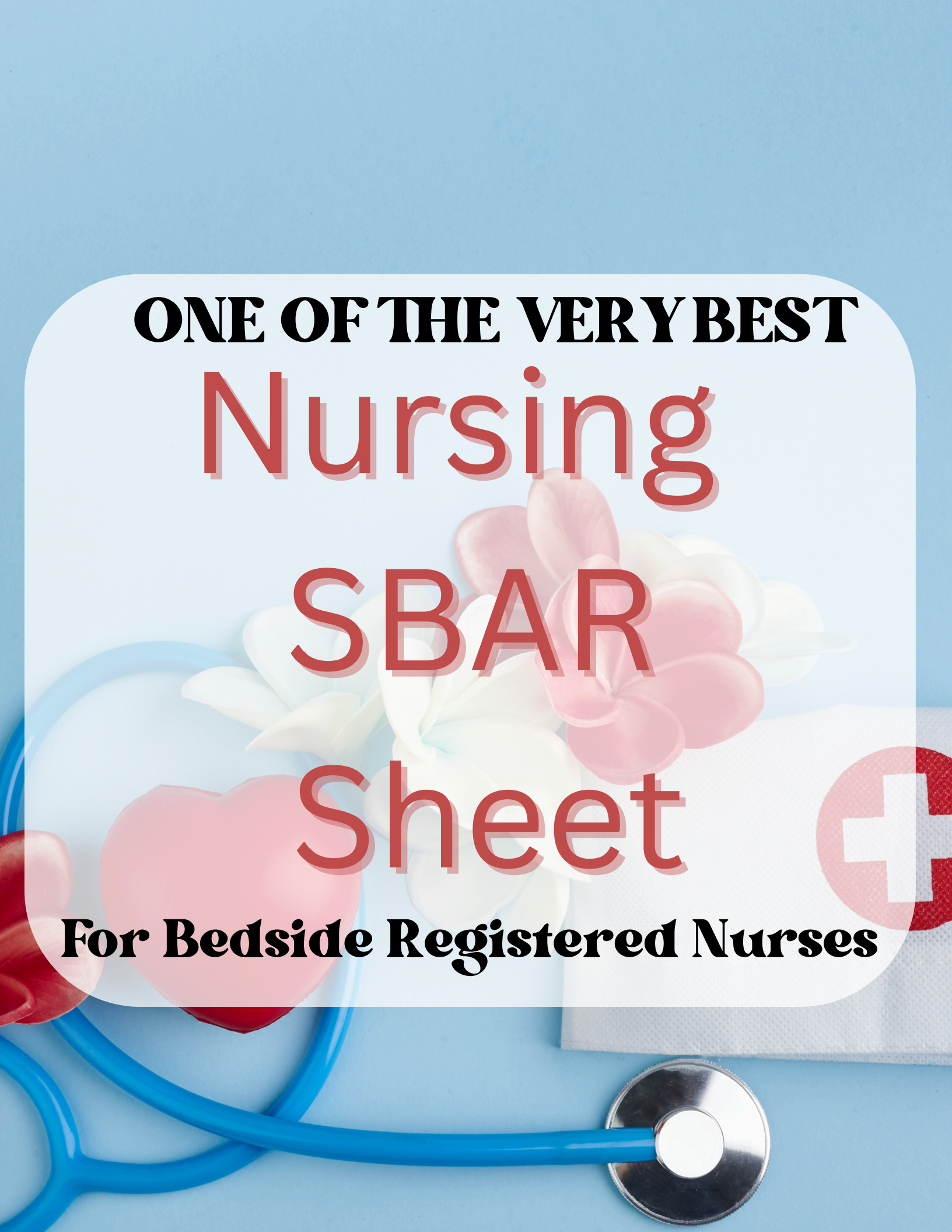
ONE OF THE VERY BEST
Nursing
SBAR
Sheet
For Bedside Registered Nurses

RM# Admit Date: Age: Gender: Code: Diet:

Patient Name: Provider:

Symptoms/Diagnosis:

History:

Allergies:

Consulting Providers: for (diagnosis):

Consulting Providers: for (diagnosis):

Consulting Providers: for (diagnosis):

Consulting Providers: for (diagnosis):

Consulting Providers:

Assessment:

Consulting Providers:

Consulting Providers: A/O x Language: Speech:

Cardio: Tele: Y N Box # Rhythm: Pattern:

Pulmo: O2: Y N Breathing Pattern: Lung Sounds:

GI/GU: Cont/Inc Ostomy Y N Type: Last BM: Foley: Y N Size/Type:

Activity: X Assist Devices: Therapy: PT OT SP Ambulatory: Y N

Skin: Wounds: Surgical:

IV Access: # R/L Continuous: CBGs: B L D HS

Labs: NA MG K CA PH CR BUN WBC HGB PLT PT/INR TROPON

Tests/Exams: Procedures:

Plan of Care:

(what is the plan how are we treating the patient: i.e diagnosis or symptoms) (Plans for discharge: i.e SNF, skilled, hospice or home?) Does social services need to provide equipment or home heath services: i.e. walker, WC, commode, or in home caregivers.)

Info: when giving report to same nurse who took care of patient a full report does not need to be given. Just update the nurse with new information.

For More Help On

Resources to help you succeed

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