SBAR NURSING REPORT SHEET

SITUATION

Name: _____

Room No. _____

DOB: _____

Age: _____ Gender: M ☐ F ☐

Code Status: _____

Fall Risk: _____

Diet: _____

Isolation Status: _____

Reason for Contact: (e.g., change in condition, concern):

_____

_____

Current Issue/Complaint:

_____

_____

Turn /Neuro Checks Q 2, 4, 6, 8:

_____

_____

BACKGROUND

Admission Date: _____

Allergies: _____

Mental Status/Functional Level:

_____

O2 Device/ Flow: _____

_____

Primary Diagnosis: _____

Relevant History (PMH/PSH):

_____

_____

_____

Previous Labs or Events: _____

_____

ASSESSMENT

HR: _____ OX: _____

BP: _____ Temp: _____

RR: _____ Pain Score: _____

Last Dose: _____

IV: _____ Last Flush: _____

Abnormal Findings/Lab Results:

_____

Symptoms: _____

_____

Head-to-Toe Highlights:

Neuro: _____

Cardiac: _____

Resp: _____ GI: _____

GU: _____ Skin: _____

RECOMENDATIONS

Provider/Nurse Contacted:

_____

Actions Taken: _____

_____

_____

Suggested Plan (e.g., order labs, increase monitoring):

_____

_____

_____

_____

Follow-Up Needed: _____

_____