Patient Name _______________________________
Record # ___________________

**SBAR**

Have ALL information AVAILABLE when reporting:
chart, allergies, medication list, pharmacy number, pertinent lab results

**SITUATION**
I am calling about ____________________________________________ (patient’s name)
The problem I am calling about is __________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**BACKGROUND**
State the primary diagnosis & reason patient is being seen for home care __________________________
State the pertinent medical history _________________________________________________________
Most recent findings
Mental status ___________________ Neuro changes _____________ Temp _____________
BP ___________________ Pulse rate/quality/rythym _____________ Resp. rate/quality _____________
Lung sounds ___________________ Pulse Oximetry _____________ % Oxygen _____________ L/min via _____________
GI/GU changes (nausea/vomiting/diarrhea/impaction/hydration) __________________________
Weight ________ (actual) Loss or Gain ________ Skin color ________ Blood Glucose _____________
Wound status (location, size, wound bed and margins, drainage type and amt, treatment and frequency)
____________________________________________________________________________________
Pain level/location/status _________________________________________________________________
Musculoskeletal changes (weakness) _______________________________________________________
DNR status ___________________________________________________________________________
Telemonitoring Report _________________________________________________________________
Other _______________________________________________________________________________

**ASSESSMENT**
☐ I think that the patient is _____________________________________________________________
OR
☐ I am not sure of what the problem is, but the patient’s status is deteriorating.

**RECOMMENDATION**
I suggest or request:
☐ PRN visit or referral: Nurse __ PT __ ST __ OT __ NH Aide __ MSW __ Dietician __
☐ Visits frequency change
☐ Schedule for a physician office visit
☐ Physician, Nurse Practitioner or Physician Assistant home visit
☐ Pulse Oximetry __ Telemonitoring __ Lab work __________________________
☐ Urinalysis, C&S __ X-rays __ EKG __
☐ Medication changes _________________________________________________________________
☐ Wound care changes _______________________________________________________________
☐ Nutrition or fluid restriction changes __________________________________________________
☐ Other ____________________________________________________________
☐ Specific patient parameters _________________________________________________________
☐ Call physician with _______________________________________________________________

Staff Name __________________________________ Date & Time _____________________________
Physician’s Name ________________________________________________________________