Place sticker here

**NURSE TO NURSE SBAR HANDOFF**
**Only complete applicable information**

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**S** ROOM NO. Admit to_______ Admission Date _________ HT:________ WT: _______
ADVANCED DIRECTIVES: ☐ No ☐ Yes ☐ Requested ☐ On chart Password: ______________
Code Status: _________________________ Family notified of procedure: ☐ Present ☐ By phone
Admitting MD: __________________ Service: _________________________
Admitting Diagnosis ______________________________________________________________________________

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**B** Allergies: _______________________________________________________________
Infectious: ☐ No ☐ MRSA ☐ VRE ☐ TB ☐ Shingles ☐ ACI ☐ CDiff ☐ Flu ☐ Other _____________
Cultures obtained: ☐ No ☐ Yes
Past Medical History: ☐ Diabetes ☐ CHF ☐ HTN ☐ MI ☐ CVA ☐ COPD
☐ Stent ☐ CABG ☐ Other ____________________________________________

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**A** Mental Status: ☐ Alert and Oriented ☐ Confused EMV ______ ☐ Communication Impairment ___________________
High Risk for falls: ☐ No ☐ Yes Hearing Aides: ☐ L ☐ R Contacts: ☐ L ☐ R Dentures ☐ Uppers ☐ Lowers
Respiratory
☐ Clear ☐ Equal ☐ Diminished R/L ☐ Wheeze R/L ☐ Rales/Rhonchi R/L
☐ O2 @ _____________ ☐ Vent Settings ______________ ☐ Airway ____________________
☐ Telemetry/Rhythm ________________________________
☐ Diet ______________ ☐ NPO since __________
☐ Feeding access ________☐ Tubefeed ________@ _____ml/hr ☐ NG size ___fr. Day # ____Clamped ☐ Low wall Sx ☐
☐ Foley size ____fr. Day # _________
☐ Dialysis Last Dialysis treatment_______ Dialysis access site __________
☐ IV gauge # _____ Site ☐ R ☐ L ☐ Lock ☐ Day # ____ Fluid _____________ @ _____ ml/hr
☐ IV gauge # _____ Site ☐ R ☐ L ☐ Lock ☐ Day # ____ Fluid _____________ @ _____ ml/hr
Fluid _____________ @ _____ ml/hr
Fluid _____________ @ _____ ml/hr
☐ Swan ☐ R ______☐ L _____ Day # ____
☐ Central line ☐ R ____☐ L ___ Type: ______ Day # ____
☐ Other Lines _______________________________________________________________
☐Art Line ☐ R ____☐ L ___ Day # ____
☐ Cardiac Device (Pacer, AICD, etc) If so Explain ___________________________
☐ Restraints Type: ____________________________
Activity Level: ☐ Ambulatory ☐ Up with assist ☐ Bedrest until _____ ☐ Logroll ☐ HOB _____
Weight-bearing status________________ ☐ SCD ______ ☐ Traction _____ - _____lbs **Specialty Bed** ___________
VS: Time ______ Temp: _____ BP: _____ P: _____ R: _____Os Sat: _____% FSBS ____________

Skin/Dressing Changes__________________________Site/Incision Checks ________________________________

Pertinent Meds given: ___________________________Meds sent with pt.__________________________________

I&O: Intake ☐ PO _____ ☐ IV _____ ☐ Bottle ☐ Other______________
Output ☐ Urine _____ ☐ Emesis _____ ☐ NG _____ ☐ Drains ______
☐ Chest Tubes _________ ☐ Diaper ☐ Other ________ ☐ Last BM ______
OR totals: ☐ EBL _________ ☐ Crystalloids ___________ ☐ Colloids _______________
☐ Anesthesia ___________________ Reversed ☐ No ☐ Yes

**R** ☐**All Orders Reviewed** : __________________**Interventions pending/needed**_________________________________
Core Measures: ☐ MI ☐ Stroke ☐ Pneumonia ☐ CHF ☐ Other _____________________________________
Social Service/Psychosocial Needs__________________________________________________________________
Comments: _____________________________________________________________________________________

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Report Received from: _________________________ Unit: ________ Ext. __________________

**This form is not part of the permanent medical record**

Created by **Transfer Protocol Committee 12/09**
**Modified 10/10**