

SBAR Medication Checklist

Identify & Situation

Introduction and reason for call

- ☐ Name of Practitioner: _____
- ☐ Your Name: _____
- ☐ Your Position: _____
- ☐ Name of Patient: _____
- ☐ Age of Patient: _____
- ☐ Patient Location: _____
- ☐ State Problem: _____
- ☐ Time of Onset: _____
- ☐ Severity: _____
- ☐ State if call is urgent: _____

Notes:

Background: Current Status and Pertinent History

Current Status

- ☐ Associated signs & symptoms: _____
- ☐ Current VS + deviation from patient's norm: _____

- ☐ Current Medications: _____
- ☐ Name, dose, frequency, route of requested medication
ordered/requested: _____
- ☐ Indication of ordered/requested medication: _____
- ☐ If call is about a medication order: who ordered the medication
and when was the order written: _____
- ☐ Current electrolytes (K⁺, NA⁺, CO₂, Cl): _____
- ☐ Routine or PRN interventions pertinent to problem: _____

Previous History

- ☐ Reason for Hospitalization: _____
- ☐ Admitting/ Working Diagnosis: _____
- ☐ Past Medical History: _____
- ☐ Previous calls for same problems: _____
- ☐ Drug allergies or adverse reactions: _____

Assessment

State your assessment of the situation

Recommendation / Request

Request or Recommend Intervention

SBAR Blood Glucose Checklist

Identify & Situation

Introduction and reason for call

- ☐ Person Called: _____
- ☐ Your Name: _____
- ☐ Your Position: _____
- ☐ Your Location: _____
- ☐ Name of Patient: _____
- ☐ Age of Patient: _____
- ☐ Patient Location: _____
- ☐ State Problem: _____
- ☐ Time of Onset: _____
- ☐ Severity: _____
- ☐ State if call is urgent: _____

Notes:

Background: Current Status and Pertinent History

Current Status

- ☐ Current Glucose Reading: _____
- ☐ Previous Glucose Reading: _____
- ☐ Associated Signs & Symptoms: _____
- ☐ Current diet: _____
- ☐ Current Electrolytes (K^+ , Na^+ , CO_2 , Cl): _____
- ☐ Current creatinine: _____
- ☐ Current VS + any deviation from patient's norm: _____
- ☐ Current Medications: _____

Pertinent History

- ☐ Reason for Hospitalization: _____
- ☐ Admitting/ Working Diagnosis: _____
- ☐ Past Medical History: _____
- ☐ Chronic/ Pre-hospitalization medications for glucose control: _____
- ☐ Time & Dose of Last Glucose Control Medication (oral hypoglycemic or insulin): _____
- ☐ Presence/Absence of Sliding Scale Insulin Order – date, time, & last dose administered: _____
- ☐ Presence/Absence of missed hypoglycemia dose in past 24 hours: _____
- ☐ Presence/Absence of infusing IV + type of fluid: _____
- ☐ Presence/Absence of labile glucose history: _____
- ☐ Routine or PRN interventions pertinent to problem: _____
- ☐ Mental Status: _____
- ☐ Skin color, temperature, & moistness: _____
- ☐ Previous calls for same problem: _____
- ☐ Drug allergies or adverse reactions: _____

Assessment

State your assessment of the situation

Recommendation / Request

Request or Recommend Intervention

SBAR Elevated Temperature Checklist

Identify & Situation

Introduction and reason for call

- ☐ Person Called: _____
- ☐ Your Name: _____
- ☐ Your Position: _____
- ☐ Your Location: _____
- ☐ Name of Patient: _____
- ☐ Age of Patient: _____
- ☐ Patient Location: _____
- ☐ State Problem: _____
- ☐ Time of Onset: _____
- ☐ Severity: _____
- ☐ State if call is urgent: _____

Notes:

Background: Current Status and Pertinent History

Current Status

- ☐ Current temperature & method of measurement (oral, ear, axillary, rectal): _____
- ☐ Temperature high & low reading over past 24 hours + method of measurement (oral, ear, axillary, rectal): _____
- ☐ Associated Signs & Symptoms: _____
- ☐ Skin color, temperature, moisture: _____
- ☐ Presence/Absence of redness, swelling, temperature, tenderness around incision site: _____
- ☐ Presence/ Absence of SOB, chest pain, cough: _____
- ☐ Presence/Absence of calf tenderness/warmth: _____
- ☐ Presence/Absence of difficulty voiding or change in urine color: _____
- ☐ Current VS + any deviation from patient's norm: _____
- ☐ Current Medications: _____

Previous History

- ☐ Reason for Hospitalization: _____
- ☐ Admitting/ Working Diagnosis: _____
- ☐ Past Medical History: _____
- ☐ Presence/Absence of chest X-ray findings & date of X-ray: _____
- ☐ Presence/Absence of antibiotics: _____
- ☐ Presence/Absence of cultures & date of findings: _____
- ☐ Presence/Absence of antipyretic medications & time last administered: _____
- ☐ Routine or PRN interventions pertinent to problem: _____
- ☐ Previous calls for same problem: _____
- ☐ Drug allergies or adverse reactions: _____

Assessment

State your assessment of the situation

Recommendation / Request

Request or Recommend Intervention

SBAR Pain Checklist

Identify & Situation

Introduction and reason for call

- ☐ Person Called: _____
- ☐ Your Name: _____
- ☐ Your Position: _____
- ☐ Your Location: _____
- ☐ Name of Patient: _____
- ☐ Age of Patient: _____
- ☐ Patient Location: _____
- ☐ State Problem: _____
- ☐ Time of Onset: _____
- ☐ Severity: _____
- ☐ State if call is urgent: _____

Notes:

Background: Current Status and Pertinent History

Current Status

- ☐ Location of pain: _____
- ☐ Cause of pain: _____
- ☐ Severity of pain: _____
- ☐ Quality of pain: _____
- ☐ Type and duration of pain episodes: _____
- ☐ Presence/Absence of radiation: _____
- ☐ Interventions that relieve pain: _____
- ☐ Factors that exacerbate pain: _____
- ☐ Associated signs & symptoms: _____
- ☐ State pertinent findings from physical assessment of patient: _____

- ☐ Current VS + deviation from patient's norm: _____
- ☐ Current Medications: _____

Pertinent History

- ☐ Reason for Hospitalization: _____
- ☐ Admitting/ Working Diagnosis: _____
- ☐ Past Medical History: _____
- ☐ Pain medications administered, dose, time last administered, patient response: _____
- ☐ Routine or PRN interventions pertinent to problem: _____
- ☐ Previous calls for same problems: _____
- ☐ Drug allergies or adverse reactions: _____

Assessment

State your assessment of the situation

Recommendation / Request

Request or Recommend Intervention
