Baptist Hospital
BAPTIST HEALTH

TRANSFER OF ACCOUNTABILITY:

SBAR Transfer of Accountability Template for Admitted Patients

S

Situation: Admission Patient's name _____ DOB _____ Age _____ Gender _____

Diagnosis: _____ Chief Complaint: _____

Abnormal Labs/Diagnostics: _____ Admitting MD: _____

Code Status: ❑ Full Code ❑ Levels of Care ❑ DNR Core Measures: ❑ AMI ❑ CAP ❑ CHF ❑ CABG ❑ Hip & Knee ❑ SCIP

❑ Medication Reconciliation Initiated ❑ NPO ❑ Isolation Type: _____ Precautions: _____

Procedures done in ED: _____

B

Background: Significant PMH Allergies: _____

Medications given prior to ED arrival: _____

A

Assessment: Vital Signs prior to transfer: ❑ Alert and Oriented T: _____ P: _____ R: _____ BP: _____ O_2Sat: _____

RESPIRATORY: ❑ WNL

❑ Decreased BS Location: _____ ❑ Chest Tube: _____

❑ Wheezes ❑ Crackles/rales ❑ Drainage amt.: _____

O2@ _____ liters via ❑ CPAP Settings: _____

❑ NC ❑ Simple Mask

❑ Venti Mask ❑ NRB

❑ Trach Size: _____ ❑ BIPAP Settings: _____

Treatments/Frequency: _____

_____

_____ ❑ Vent Settings: _____

CARDIAC: ❑ WNL

❑ Telemetry/Indications: _____

❑ Meets criteria for nurse transport

Rhythm: _____

Edema: _____

Pulses: _____

❑ Pacer

❑ Defibrillator

❑ Central Line

NEURO: ❑ WNL

❑ Confused

❑ Responds to Verbal

❑ Responds to Pain

❑ Unresponsive

❑ Speech Slurred

Weakness: ❑ R ❑ L

❑ Neuro ✓s: _____

❑ Pupils: _____

Ambulatory Status: _____

GU: ❑ WNL

❑ Foley

❑ Incontinent Urine output: _____

PAIN: ❑ NA

❑ Prior to transfer (intensity, location and quality)

_____

GI: ❑ WNL

Diet: _____

Bowel sounds: _____

❑ Tender ❑ Distended

❑ Firm ❑ NG/PEG/ND

Last BM: _____

SKIN

❑ Intact: _____

❑ Bruising ❑ Tears

❑ Wound Location/Describe: _____

_____

DRIPS: *(Include DC time if applicable)*

Tubes/Lines: _____

_____

Time	Medication	Response	Time	Medication	Response

R

Recommendations: **Pending Labs/Diagnosis:**

ACCUCHEKS: ❑ NA

❑ AC ❑ HS

Other: _____

❑ Sliding scale

STANDING ORDERS: ❑ NA

❑ Temp: _____ ❑ HR: _____

❑ BP: _____

❑ Other: _____

Consultant	Reason for Consult	Notified	Called Back

Special Needs, Status Changes:

Report given by: _____ Time: _____ Contact phone: _____ Bed Assigned: _____

Form #4331 (Rev. 10/08)

Source: Baptist Hospital of Miami.