**SBAR Communication Framework**

**Information Exchange**

**SBAR**

**Situation**
- Brief description of patient (name, age, gender)
- Date and reason for presentation/admission
- Treating doctor
- Primary diagnosis
- Current clinical status (e.g. stable, deteriorating, improving)

**Background**
- Significant history relevant to the current presentation/admission
- Relevant co-morbidities/infectious status
- Allergies/alerts
- Advanced Health Directive and/or Acute Resuscitation Plan
- Usual living/social situation
- Current treatment plan/recovery goals
- Recent changes/progress with treatment

**Assessment**
- Clinical observations/monitoring
- Current condition (observations, vital signs)
- Physical status: wound assessment: infectious status
- Outcome of any investigations
- Clinical risk assessment and any clinical incidents
- Progress toward discharge goals including continuing care

**Recommendations**
- Planned interventions
- Anticipated changes in treatment
- Infection precautions
- Potential changes in condition
- Specific monitoring required - frequency of observations
- Medication/treatment effects
- Discharge/leave planning