McLaren Business Products

McLaren Print System Order

Order No: 9687
Order Date: 2015-03-09
User: Shelby Reed
Phone: 810-342-2546

Ship Location: Shelby Reed - 5 South ACP Office
401 South Ballenger Highway
Flint, MI 48532
Forms
Quantity: 1000
Paragon Dept No: 91020
Dept Name: Nursing Admin
Company Number: 60

Order Total Price: 0.00

Item Number: 17921
Item Description: Post-Fall SBAR
Revision Date: 3/2015
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: None
Misc Info:

McLaren Flint
FLINT, MICHIGAN

POST-FALL SBAR

Situation

Date of fall:_____ Time of fall:_____ Room #:_____ Unit:_____

Witnessed: ☐ Yes ☐ No Hit Head: ☐ Yes ☐ No Activity before fall (use Key):_____

Most recent fall assessment: ☐ 0-12 hrs ☐ 12-24 hrs ☐ >24 hrs

Morse Fall Scale Score:_____

Brief explanation of fall:_____

Background

Relevant patient history/symptoms (use Key):_____

What is the patient's cognition history (use Key):_____

Does the patient have osteoporosis? ☐ Yes ☐ No

Previously or currently on anticoagulation therpy? ☐ Yes ☐ No

Low platelet count? ☐ Yes ☐ No Previous fall this hospitalization? ☐ Yes ☐ No

Assessment

Injury (use key): _____ Pain related to fall: _____

Neuro assessment _____ Glasgow Coma Score _____

T:_____ P:_____R:_____BP:_____O2 Sat:_____ Accu-check (for diabetic) _____

High risk medications received within 4 hours before the fall: (note if new)

Medication	Time Given	Medication	Time Given
☐ PCA/Opiate	_____	☐ Antihypertensive	_____
☐ Hypnotic	_____	☐ Sedative	_____
☐ Anticonvulsant	_____	☐ Diuretic	_____
☐ Laxative	_____	☐ Psychotropic	_____

Recommendation

CT scan completed: Date:_____ Time:_____ Other treatment or testing provided:_____

Physician(s) notified:_____ Date:_____ Time:_____

Was patient transferred off of the unit following the fall? ☐ Yes ☐ No To room #:_____

Signature of RN:_____**Date:**_____ **Time:**_____

Post-FALL SBAR

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