McLaren
FLINT

SBAR Radiation Transport

S	**Situation** **Patient Name:** _____ **Room #:** _____ **Nurse's Name:** _____ **Unit Phone #:** _____ **Nurse's Signature:** _____ **Date/Time:** _____
B	**Background** **Admission Diagnosis:** _____ **Date of Treatment:** _____ **Pertinent past medical history:** _____ **Allergies:** _____ **Code Status:** _____ (advance directives, DNR, POA for health care)
A	**Assessment** **Vital Signs:** _____ **IV site:** _____ **Current Pain Score:** _____ **Procedures done in the last 24 hours** (include any known results): _____ **Safety needs/fall risk/etc.:** _____
R	**Recommendation** **EMS Company:** _____ **Pick up time (inpatient):** _____ **Pick up time (radiation center):** _____

Post Radiation Report

Note: _____

_____

_____

_____

Radiation Therapist's Name: _____

Radiation Therapist's Signature: _____ Date/Time: _____

870

PT.

MR.#/P.M.

DR.