**SBAR Wound and Skin   
Provider Communication Record**  
  
  
Patient: DOB:

[insert your logo here]

Nurse/Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| S | SITUATION | | | | |
| --- | --- | --- | --- | --- | --- |
| Area(s) of concern: | | Wound treatment | Wound infection | New wound |
| Consultant recommendation | | Skin problem | Incision line | Other: |
| Vital signs from personal assessment of the patient: | | | | |
| Blood pressure: | |  | Respiration: |  |
| Pulse: | |  | Temperature: |  |
| B | BACKGROUND | | | | |
| Type of wound: | | Pressure | Venous | Diabetic |
| Arterial | | Surgical | Other: |  |
| Wound Location: | |  | | |
| Measurement: | | Length: cm | Width: cm | Depth: cm |
| Wound base: | | Granulation: % | Slough: % | Eschar: % |
|  | | Epithelial: % | Other:\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Drainage: | | Amount: | Color: | Odor: |
| Surrounding Tissue: | Edema | | Intact | Induration |
| Pallor | | Lesions | Staining | Macerated |
| Calloused | | Epiboly | Undermining | Tunneling |
| Weeping | |  |  |  |
| Indicators of infection: | | Fever | Streaking | Redness |
| Warmth | | Odor | Pain | Increased drainage |
| Induration | | Malaise | Other: |  |
| Past Treatment: | |  | | |
| Current treatment: | |  | | |
| Lab results: | |  | | |
| A | ASSESSMENT | | | | |
| Wound progress: | | Healing | Worsening | Remaining stagnant |
| Potential problem: | | | | |
| I am unable to determine the problem, and the patient is deteriorating. | | | | |
| The patient seems unstable and may get worse: action is required. | | | | |
| Other: | | | | |
| R | RECOMMENDATION | | | | |
| Change treatment: | | | Start interventions: | |
| Obtain labs: | | | Obtain a consult: | |
| Office visit today or within 24 hours | | | Transfer patient: | |
| Other: | | | | |

Notes:

Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_Time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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