Communication and assessment information for GP



RN NSW

Attention: Dr	Resident's name:	
RACF:	Staff member:	Date: Time:
ISBAR communication tool	Clinical asses	sment
l dentify Identify self, receiver and resident 	Temperature: Pu	Ilse: Advanced care directive: yes / no
S ituation	Respirations: Oxygen therapy:	/ minute SaO2: % continuous / intermittent / as required / not used
 State why you are calling What is currently happening If urgent, say so 	Blood pressure : Blood glucose level:	/ lying / standing mmol
B ackground • Date and time of event • History of event • Brief medical and	Bowels last opened: Urinalysis: Urine output: similar / les	consistency / colour Allergies: ss / more
 Brief summary of actions taken 	Fluid intake: same / les Vomiting: yes / no	s / more Food intake: same / less / more amount / colour / type
A ssessment • Clinical assessment • Vital signs	Pain: yes / no Last seen by a GP: Recent treatment for infect	· · · ·
R equest State what you want from them What else should you do 	Confusion / change in aler Medications given to help Other:	

Acknowledgements This resource has been updated by COORDINARE – South Eastern NSW PHN based on documents developed by Southern NSW Medicare Local, Hornsby Ku-rin-gai Health Service and the Southern Tasmanian Area Health Service. Disclaimer The medical information provided in this guideline is intended as a guide for the management of the acutely unwell and deteriorating resident. The use of this guideline is not intended to provide a substitute for medical advice on the diagnosis and treatment of certain medical conditions. Any resident requiring medical advice or treatment must be referred to their treating General Practitioner or Nurse Practitioner. While the author's of this guideline takes every precaution to ensure the currency and accuracy of all medical information contained in the guideline, the author/s does not offer any warranties as to the currency of information in this guideline.