Palliative Care SBAR Communication Tool

Situation

PPS ESAS

Symptom	Date	Date
Pain		
Tired		
Nausea		
Depressed		
Anxious		
Drowsy		
Appetite		
Well-being		
Shortness of breath		
Other:		

I have concerns about ____________________

Name ____________________ DOB ______ . ______ . ______
MM DD YR

Health Card Number ____________________ Gender __________

☐ The problem I am calling about is… ☐ The reason for transfer is…

____
____
____
____

SRK In Home EDITH Completed

Allergies ____________________

Background

Diagnosis ____________________

History of illness, related factors

____
____

Symptoms	Current Medications (or attach medication sheet)	

Assessment

Onset
Provoking/Palliating
Quality
Region/Radiation
Severity
Treatment
Understanding/Impact on you
Values

O ____________________
P ____________________
Q ____________________
R ____________________
S ____________________
T ____________________
U ____________________
V ____________________

Recommendations

☐ Can you please visit to assess

____
____

☐ Upon arrival can you please assess

____

I recommend…/my thoughts are…/I wonder if…?

____
____
____
____

Nurse's Name/Agency: ____________________
Contact number: ____________________
Date: ____________________