Use this tool to help facilitate efficient and safe communications about patients, including facility transfers and handover of care between providers.

**S** Situation
- Identify yourself & location
- Identify patient (name, age, sex)
- State diagnosis (suspected or definitive)
- State reason for transfer or handover (e.g. unavailable diagnostics or therapeutics)

**B** Background
- Admission date
- Relevant past medical & surgical history
- Recent changes in status (ABCDE findings/interventions)
- Relevant labs & imaging
- Recent vital signs
- Management or interventions provided (e.g. O2, infusions, antibiotics, procedures)
- Relevant psychosocial factors

**A** Assessment
- State the diagnoses or conditions (if diagnostic uncertainty)
- State severity of illness (stable or critical)
- State patient trajectory (worsening or improving)
- Report response to interventions provided

**R** Recommendation
- State your recommendations & concerns (e.g. transfer for specialist consult or frequent monitoring)
- State timeline for recommendations (e.g. transfer or intervention needed in next 1 hour)
- State contingency plans (e.g. If patient transfer is delayed, then I will...)

**Confirmation: Ask receiver to repeat back key information and clarify any questions**