Margaret H. Rollins School of Nursing
Student End of Care (SBAR) Report to Staff

Situation	Mom: Name, Age, GTPAL/GP, Delivery, Complications of Delivery
	Baby: Gender, APGARs, Birth Weight, Gestational Age, Complications
Background	Mom: Why here? (Scheduled IOL, Spontaneous, C/S- stat or planned, etc.) Blood type, GBS, abnormal labs Delivery trauma (lac, epis, etc) Pain level, last medication admin Feeding plan
	Baby: Void/Stools How feeding is going- amount, last time fed, frequency?
Assessment	Mom: Uterine Assessment- fundal height, location, consistency Lochia Assessment- amount, color, consistency Emotional Assessment Abnormal findings from BUBBLE-HE Voiding? VS Pain level currently
	Baby: VS Abnormal assessment findings Screening measures and results HMD? Hearing Screen? Pass/Fail? CCHD? SpO2 Results? Bili? Bath? Last feed Glucose levels
Recommendations	Mom: Next medication time Upcoming treatments Next assessment time
	Baby: Any screening measures that need to be completed Bath to be completed Upcoming glucose measurements needed Due to feed again when