

ISOBAR Patient Handover

IDENTIFY	Add patient sticker	
	Name	
	Age	
	Gender	
	Date of birth	
SITUATION <ul style="list-style-type: none"> Purpose of transfer Anticipated course and complications Advanced care directives 		
OBSERVATIONS Time taken: _____:____ AM/PM	HEART RATE	_____/min
	RESPIRATORY RATE	_____/min
	OXYGEN SATURATION	____% RA / O ₂ > ____ L/min
	BLOOD PRESSURE	____ / ____ mmHG
	TEMPERATURE	____°C
BACKGROUND <ul style="list-style-type: none"> Patient assessment History relevant to presenting complaint/injury and mechanism Medications Medical history 		
AGREE TO PLAN <ul style="list-style-type: none"> Interventions Response to treatment 		
Mental Health Transfers The use of sedation as per SJWA guidelines is approved for this patient in the event less restrictive measures have failed: <input type="checkbox"/> YES <input type="checkbox"/> NO	If authorised, please complete special medication authority section. Name and contact number of attending doctor	
	Name	
	Contact number	
READ BACK All concerned understand and are happy with the plan	Signature: Ambulance staff	
	Signature: Attending doctor/nurse	
SPECIAL MEDICATION AUTHORITY <ul style="list-style-type: none"> Indications for administration Medication name Medication dosage Repeated / subsequent dosages(s) 		