ICU Report Sheet: SBAR Brain Sheet for Nurses

A printable system-by-system report layout, how to give SBAR handoff in the ICU, and what to check together at the bedside

ICU Basics
icubasics.com · checked Oct 2026

ICU REPORT SHEET TEMPLATE (SBAR BRAIN SHEET)

An ICU report sheet, or brain sheet, is a one-page form that holds one critically ill patient by body system so you can take report, track the shift and give SBAR handoff without missing anything. Print this page, use one per patient, and fill each row in pencil as the shift changes.

Original layout. Use as a personal worksheet and follow your hospital's rules on patient information.

ROW	WRITE DOWN	YOUR NOTES
Patient	Name, age, room, weight (kg), code status, allergies, isolation	
Situation	Why in the ICU now; today's main problem	
Background	Admit diagnosis and date, key history, procedures, hospital course	
Neuro	GCS or RASS, CAM-ICU, pupils, pain score, sedation and goal, seizures, ICP/EVD	
Cardiac	Rhythm, HR, BP and MAP goal, arterial line, CVP or PA numbers, pacing, pulses, edema	
Drips	Drug, concentration, dose, rate in mL/h, titration goal, line and port	
Respiratory	Airway and size at the lip, mode, FiO_2, PEEP, rate, tidal volume, SpO_2, last ABG, secretions, SBT plan	
GI and nutrition	Diet or tube feed and rate, residual policy, last BM, bowel regimen, GI prophylaxis, glucose	
Renal	Urine output per hour, Foley or CRRT settings, creatinine, K, Mg, Phos, fluid balance	
Heme and ID	Hgb, platelets, coags, anticoagulation, blood products; temp, WBC, cultures, antibiotics and times	
Skin and lines	Wounds, pressure injuries, turns; every line, tube and drain with site and date	
Family and plan	Who to call, goals of care, consults, procedures, scans	
To do	Timed meds, labs, rechecks, orders to clarify	

HOW TO GIVE SBAR HANDOFF IN THE ICU

PART	IN ICU REPORT	EXAMPLE
S: Situation	Who, why here, how they are now	64-year-old, septic shock from pneumonia, day 2, on norepinephrine
B: Background	History and course that change care	COPD, CKD 3; intubated yesterday; cultures pending
A: Assessment	System by system, unstable systems first, with trends	MAP 66–70 on 0.12 mcg/kg/min, lactate down from 4.1 to 2.3
R: Recommendation	What needs doing, what to watch, open questions	Wean norepinephrine to MAP 65; repeat lactate at 0400; SBT in the morning

- Lead with what could hurt the patient in the next hour: an unstable rhythm, a drip at its limit, a bleeding site.
- Give numbers with direction: "creatinine 2.1, up from 1.6" beats "creatinine is high".
- Say what you did not get to and what is pending.
- The receiving nurse reads back critical items and asks questions before the giver leaves.

BEDSIDE HANDOFF CHECKLIST

Finish report at the bedside, together. Introduce yourself to the patient and family, invite them in where appropriate, and lower your voice for anything sensitive.

- Look at the patient: breathing, color, comfort, restraints and skin.
- Airway and ventilator: settings match the order; tube secured and size at the lip noted.
- Every drip: drug, concentration and rate on the pump match the order and the bag; pump channel and line labeled.
- Lines and drains: follow each from the patient to the pump or collection device; sites and dressings.
- Monitor: alarms on and limits set for this patient; arterial line leveled and waveform clean.
- Safety: suction working, bag-valve mask and oxygen at the bedside, bed low and locked, call light in reach.

SAFETY If a drip, setting or order does not match, fix it or escalate before the off-going nurse leaves.

Sources (3) are listed with links at icubasics.com/sheets/icu-report-sheet.html. For education and exam preparation only. Not medical advice; follow current guidelines and your institution's protocols. ICU Basics is an independent study aid not affiliated with any certifying body.