ISBAR AOD CLINICAL HANDOVER

Fillable template | Introduction, Situation, Background, Assessment and Recommendation

I — Introduction

I am... the patient/client is... I work at...

Introduce yourself, role and location; introduce team members; use at least 3 approved identifiers; include the patient/client, family or carer when appropriate.

S — Situation

I have a patient/client who is... with... and at risk of...

State the immediate clinical situation and AOD concern. Identify deterioration, falls, allergies, injecting drug use, resuscitation limits, security, child protection, intoxication, withdrawal or mental health risk.

B — Background

The clinical background, history and context are...

Summarise relevant history and records: substances, amount, frequency, route, last use, withdrawal/overdose, OAT medicine/dose/last dose/missed doses, medicines, medical, mental health and psychosocial context.

A — Assessment

The problem seems to be... we are addressing risk by...

Use A-G where indicated. Include observations, medication, withdrawal tool/score, mental state, current risk management, CERS breach and intoxication, overdose, self-harm, violence, medical or safeguarding risks.

R — Recommendation

What is recommended? What needs to be done? Who will do it and by when?

State recommendations, discharge plan, referrals, further assessments/actions, responsible clinician/service, timeframe, observation frequency, escalation triggers, repeat-back and eMR documentation.

Closed-loop confirmation

Receiver / service

Date / time / method

Review / escalation timeframe

Agreed actions and care owner

- ☐ Repeat-back confirmed
- ☐ Documented in eMR
- ☐ Patient/carer informed where appropriate

ISBAR AOD CLINICAL HANDOVER

Completed example | Fictional case for staff education

FICTIONAL EXAMPLE: Adult referred by GP after missing 6 consecutive methadone doses. The example demonstrates structure only and is not a dosing instruction.

I — Introduction

I am... the patient/client is... I work at...

Introduce yourself, role and location; introduce team members; use at least 3 approved identifiers; include the patient/client, family or carer when appropriate.

S — Situation

I have a patient/client who is... with... and at risk of...

State the immediate clinical situation and AOD concern. Identify deterioration, falls, allergies, injecting drug use, resuscitation limits, security, child protection, intoxication, withdrawal or mental health risk.

B — Background

The clinical background, history and context are...

Summarise relevant history and records: substances, amount, frequency, route, last use, withdrawal/overdose, OAT medicine/dose/last dose/missed doses, medicines, medical, mental health and psychosocial context.

A — Assessment

The problem seems to be... we are addressing risk by...

Use A-G where indicated. Include observations, medication, withdrawal tool/score, mental state, current risk management, CERS breach and intoxication, overdose, self-harm, violence, medical or safeguarding risks.

R — Recommendation

What is recommended? What needs to be done? Who will do it and by when?

State recommendations, discharge plan, referrals, further assessments/actions, responsible clinician/service, timeframe, observation frequency, escalation triggers, repeat-back and eMR documentation.

Closed-loop confirmation

Receiver/service: Drug Health Intake Clinician | 23 Sep 2026, 10:20, telephone
Agreed actions/owner: Intake clinician to arrange same-day prescriber review; GP to continue interim monitoring and advise ED/000 if deterioration.
Review/escalation: Same day. Repeat-back confirmed; handover documented; patient informed.

ISBAR AOD CLINICAL HANDOVER

Completed example 2 | Alcohol withdrawal | Fictional case for staff education

FICTIONAL EXAMPLE: Adult with alcohol dependence and previous withdrawal seizure. This example demonstrates handover structure only. Medication and monitoring must follow the authorised clinical plan and local procedure.

I — Introduction

I am... the patient/client is... I work at...

Introduce yourself, role and location; identify the patient/client with at least 3 approved identifiers; include the patient or carer where appropriate.

This is Taylor Morgan, Drug Health CNS at Western Sydney Drug Health. I am handing over Sam Patel, DOB 03/08/1972, MRN 7654321, currently in the medical assessment unit. Sam has consented to the handover and is present.

S — Situation

I have a patient/client who is... with... and at risk of...

State the immediate clinical situation, the alcohol-withdrawal concern and the immediate deterioration risks.

Sam is alcohol dependent and is developing withdrawal after the last drink at approximately 18:00 yesterday. Tremor, sweating, nausea and increasing anxiety are present. The immediate risks are progression to severe withdrawal, seizure, delirium, dehydration and falls.

B — Background

The clinical background, history and context are...

Summarise alcohol pattern, last use, previous withdrawal complications, medical history, medicines, supports and relevant records.

Sam reports approximately one bottle of spirits daily for several years. There was a previous alcohol-withdrawal seizure in 2024 and a past admission for severe withdrawal. Medical history includes hypertension and liver disease. Oral intake has been poor for two days. No reported benzodiazepine or opioid use. Lives alone; sibling is the nominated support person.

A — Assessment

The problem seems to be... we are addressing risk by...

Include A-G findings, observations, withdrawal signs/score, mental state, current risk management and CERS status where relevant.

Alert and oriented but visibly tremulous and diaphoretic. Pulse 108, BP 158/96, RR 18, SpO2 97%, temperature 37.1 C. Nausea present; no current hallucinations or seizure activity. Alcohol-withdrawal score is elevated and increasing on repeat assessment. Falls and seizure precautions are in place. Medical review is required because of previous seizure, liver disease and worsening observations.

R — Recommendation

What is recommended? What needs to be done? Who will do it and by when?

State the required actions, responsible clinician/service, timeframe, monitoring frequency, escalation triggers, repeat-back and documentation.

Please complete urgent medical review and manage withdrawal under the authorised alcohol-withdrawal plan and local procedure. Continue frequent observations and repeat the approved withdrawal assessment as ordered. Address hydration, nutrition and thiamine/Wernicke prevention under the medical plan. Escalate immediately for seizure, confusion, hallucinations, marked agitation, reduced consciousness, worsening observations or CERS criteria. Confirm the receiving team, repeat back the plan and document in eMR.

Closed-loop confirmation

Receiver/service: Medical registrar and shift coordinator | 23 Sep 2026, 11:15, bedside and telephone
Agreed actions/owner: Medical registrar to review immediately; nursing team to continue ordered observations, falls/seizure precautions and escalation.
Review/escalation: Immediate review and reassessment as ordered. Repeat-back confirmed; documented in eMR; patient informed.