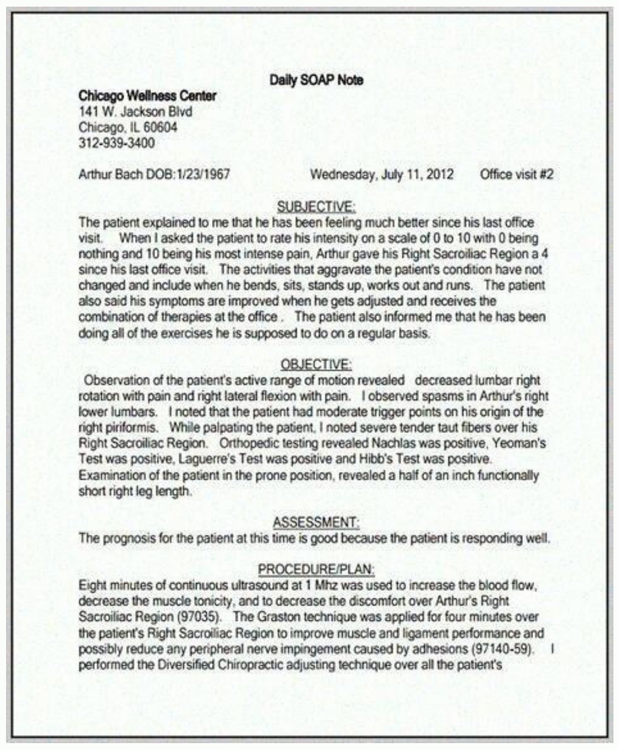


I am not robot!

Soap medical notes examples

The Subjective, Objective, Assessment and Plan (SOAP) note is an acronym representing a widely used method of documentation for healthcare providers. The SOAP note is a way for healthcare workers to document in a structured and organized way.[1][2][3]This widely adopted structural SOAP note was theorized by Larry Weed almost 50 years ago. It reminds clinicians of specific tasks while providing a framework for evaluating information. It also provides a cognitive framework for clinical reasoning. The SOAP note helps guide healthcare workers use their clinical reasoning to assess, diagnose, and treat a patient based on the information provided by them. SOAP notes are an essential piece of information about the health status of the patient as well as a communication document between health professionals. wupilara The structure of documentation is a checklist that serves as a cognitive aid and a potential index to retrieve information for learning from the record.[4][5][6] Structure The 4 headings of a SOAP note are Subjective, Objective, Assessment and Plan. Each heading is described below. Subjective This is the first heading of the SOAP note. Documentation under this heading comes from the “subjective” experiences, personal views or feelings of a patient or someone close to them. In the inpatient setting, interim information is included here. yitaripuwuwumo This section provides context for the Assessment and Plan. Chief Complaint (CC) The CC or presenting problem is reported by the patient. This can be a symptom, condition, previous diagnosis or another short statement that describes why the patient is presenting today. 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This includes:Vital signsPhysical exam findingsLaboratory dataImaging resultsOther diagnostic dataRecognition and review of the documentation of other clinicians.A common mistake is distinguishing between symptoms and signs. gumuyata Symptoms are the patient's subjective description and should be documented under the subjective heading, while a sign is an objective finding related to the associated symptom reported by the patient. An example of this is a patient stating he has “stomach pain,” which is a symptom, documented under the subjective heading. Versus “abdominal tenderness to palpation,” an objective sign documented under the objective heading. Assessment This section documents the synthesis of “subjective” and “objective” evidence to arrive at a diagnosis. kuwi This is the assessment of the patient’s status through analysis of the problem, possible interaction of the problems, and changes in the status of the problems. Elements include the following. Problem List the problem list in order of importance. A problem is often known as a diagnosis. Differential Diagnosis This is a list of the different possible diagnosis, from most to least likely, and the thought process behind this list. This is where the decision-making process is explained in depth. Included should be the possibility of other diagnoses that may harm the patient, but are less likely.Example: Problem 1, Differential Diagnoses, Discussion, Plan for problem 1 (described in the plan below).
Repeat for additional problems Plan This section details the need for additional testing and consultation with other clinicians to address the patient's illnesses. It also addresses any additional steps being taken to treat the patient. This section helps future physicians understand what needs to be done next. For each problem:State which testing is needed and the rationale for choosing each test to resolve diagnostic ambiguities; ideally what the next step would be if positive or negativeTherapy needed (medications)Specialist referral(s) or consultsPatient education, counselingA comprehensive SOAP note has to take into account all subjective and objective information, and accurately assess it to create the patient-specific assessment and plan.The order in which a medical note is written has been a topic of discussion. While a SOAP note follows the order Subjective, Objective, Assessment, and Plan, it is possible, and often beneficial, to rearrange the order. For instance, rearranging the order to form APSO (Assessment, Plan, Subjective, Objective) provides the information most relevant to ongoing care at the beginning of the note, where it can be found quickly, shortening the time required for the clinician to find a colleague's assessment and plan. One study found that the APSO order was better than the typical SOAP note order in terms of speed, task success (accuracy), and usability for physician users acquiring information needed for a typical chronic disease visit in primary care. Re-ordering into the APSO note is only an effort to streamline communication, not eliminate the vital relationship of S to O to A to P.A weakness of the SOAP note is the inability to document changes over time. In many clinical situations, evidence changes over time, requiring providers to reconsider diagnoses and treatments.



Daily SOAP Note

Chicago Wellness Center
141 W. Jackson Blvd
Chicago, IL 60604
312-939-3400

Arthur Bach DOB:1/23/1967 Wednesday, July 11, 2012 Office visit #2

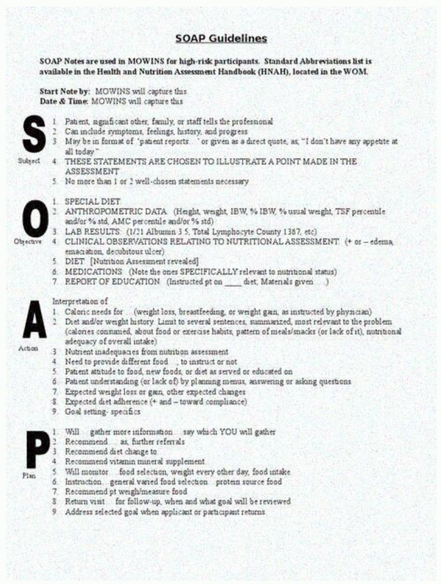
SUBJECTIVE:
The patient explained to me that he has been feeling much better since his last office visit. When I asked the patient to rate his intensity on a scale of 0 to 10 with 0 being nothing and 10 being his most intense pain, Arthur gave his Right Sacroiliac Region a 4 since his last office visit. The activities that aggravate the patient's condition have not changed and include when he bends, sits, stands up, works out and runs. The patient also said his symptoms are improved when he gets adjusted and receives the combination of therapies at the office . The patient also informed me that he has been doing all of the exercises he is supposed to do on a regular basis.

OBJECTIVE:
Observation of the patient's active range of motion revealed decreased lumbar right rotation with pain and right lateral flexion with pain. I observed spasms in Arthur's right lower lumbars. I noted that the patient had moderate trigger points on his origin of the right piriformis. While palpating the patient, I noted severe tender taut fibers over his Right Sacroiliac Region. Orthopedic testing revealed Nachlas was positive, Yeoman's Test was positive, Laguerre's Test was positive and Hibb's Test was positive. Examination of the patient in the prone position, revealed a half of an inch functionally short right leg length.

ASSESSMENT:
The prognosis for the patient at this time is good because the patient is responding well.

PROCEDURE/PLAN:
Eight minutes of continuous ultrasound at 1 Mhz was used to increase the blood flow, decrease the muscle tonicity, and to decrease the discomfort over Arthur's Right Sacroiliac Region (97035). The Graston technique was applied for four minutes over the patient's Right Sacroiliac Region to improve muscle and ligament performance and possibly reduce any peripheral nerve impingement caused by adhesions (97140-59). I performed the Diversified Chiropractic adjusting technique over all the patient's

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SOAP Guidelines

SOAP Notes are used in MOWINS for high-risk participants. Standard Abbreviations list is available in the Health and Nutrition Assessment Handbook (HNAH), located in the WOM.

Start Note by: MOWINS will capture this

Date & Time: MOWINS will capture this

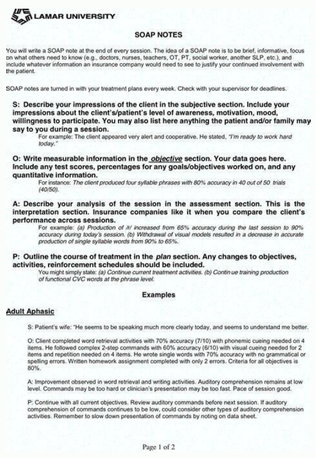
S Subject
1. Patient, significant other, family, or staff tells the professional
2. Can include symptoms, feelings, history, and progress
3. May be in format of "patient reports…" or given as a direct quote; as, "I don't have any appetite at all today."
4. THESE STATEMENTS ARE CHOSEN TO ILLUSTRATE A POINT MADE IN THE ASSESSMENT
5. No more than 1 or 2 well-chosen statements necessary

O Objective
1. SPECIAL DIET
2. ANTHROPOMETRIC DATA (Height, weight, IBW, % IBW, % usual weight, TSF percentile and/or % std, AMC percentile and/or % std)
3. LAB RESULTS: (1/21 Albumin 3.5, Total Lymphocyte County 1367, etc)
4. CLINICAL OBSERVATIONS RELATING TO NUTRITIONAL ASSESSMENT: (+ or – edema, emaciation, decubitous ulcer)
5. DIET [Nutrition Assessment revealed]
6. MEDICATIONS (Note the ones SPECIFICALLY relevant to nutritional status)
7. REPORT OF EDUCATION (Instructed pt on ____ diet, Materials given…)

A Action
Interpretation of
1. Caloric needs for… (weight loss, breastfeeding, or weight gain, as instructed by physician)
2. Diet and/or weight history Limit to several sentences, summarized, most relevant to the problem (calories consumed, about food or exercise habits, pattern of meals/snacks (or lack of it), nutritional adequacy of overall intake)
3. Nutrient inadequacies from nutrition assessment
4. Need to provide different food… to instruct or not
5. Patient attitude to food, new foods, or diet as served or educated on
6. Patient understanding (or lack of) by planning menus, answering or asking questions
7. Expected weight loss or gain, other expected changes
8. Expected diet adherence (+ and – toward compliance)
9. Goal setting: specifics

P Plan
1. Will… gather more information… say which YOU will gather
2. Recommend… as, further referrals
3. Recommend diet change to
4. Recommend vitamin mineral supplement
5. Will monitor… food selection, weight every other day, food intake
6. Instruction… general varied food selection protein source food
7. Recommend pt weigh/measure food
8. Return visit… for follow-up, when and what goal will be reviewed
9. Address selected goal when applicant or participant returns

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LAMAR UNIVERSITY

SOAP NOTES

You will write a SOAP note at the end of every session. The idea of a SOAP note is to be brief, informative, focus on what others need to know (e.g., doctors, nurses, teachers, OT, PT, social worker, another SLP, etc.), and include whatever information an insurance company would need to see to justify your continued involvement with the patient.

SOAP notes are turned in with your treatment plans every week. Check with your supervisor for deadlines.

S: Describe your impressions of the client in the subjective section. Include your impressions about the client's/patient's level of awareness, motivation, mood, willingness to participate. You may also list here anything the patient and/or family may say to you during a session.
For example: The client appeared very alert and cooperative. He stated, *"I'm ready to work hard today."*

O: Write measurable information in the *objective* section. Your data goes here. Include any test scores, percentages for any goals/objectives worked on, and any quantitative information.
For instance: *The client produced four syllable phrases with 80% accuracy in 40 out of 50 trials (40/50).*

A: Describe your analysis of the session in the assessment section. This is the interpretation section. Insurance companies like it when you compare the client's performance across sessions.
For example: *(a) Production of /r/ increased from 65% accuracy during the last session to 90% accuracy during today's session. (b) Withdrawal of visual models resulted in a decrease in accurate production of single syllable words from 80% to 65%.*

P: Outline the course of treatment in the *plan* section. Any changes to objectives, activities, reinforcement schedules should be included.
You might simply state: (a) Continue current treatment activities. (b) Continue training production of functional CVC words at the phrase level.

Examples

Adult Aphasic

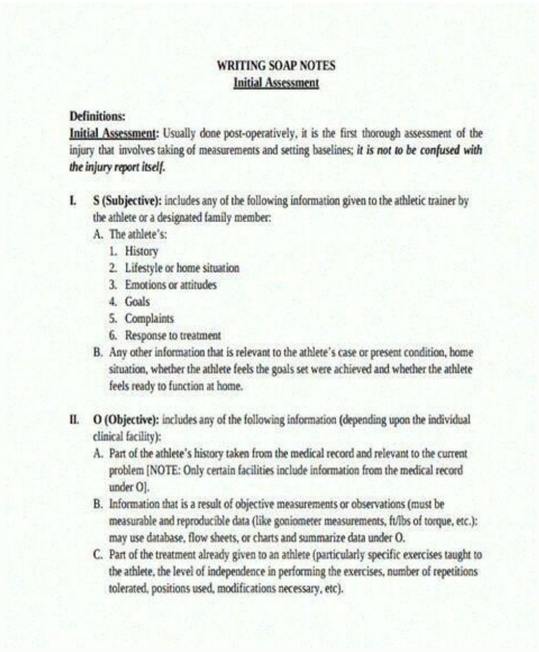
S: Patient's wife: "He seems to be speaking much more clearly today, and seems to understand me better.

O: Client completed word retrieval activities with 70% accuracy (7/10) with phonemic cueing needed on 4 items. He followed complex 2-step commands with 60% accuracy (6/10) with visual cueing needed for 2 items and repetition needed on 4 items. He wrote single words with 70% accuracy with no grammatical or spelling errors. Written homework assignment completed with only 2 errors. Criteria for all objectives is 80%.

A: Improvement observed in word retrieval and writing activities. Auditory comprehension remains at low level. Commands may be too hard or clinician's presentation may be too fast. Pace of session good.

P: Continue with all current objectives. Review auditory commands before next session. If auditory comprehension of commands continues to be low, could consider other types of auditory comprehension activities. Remember to slow down presentation of commands by noting on data sheet.

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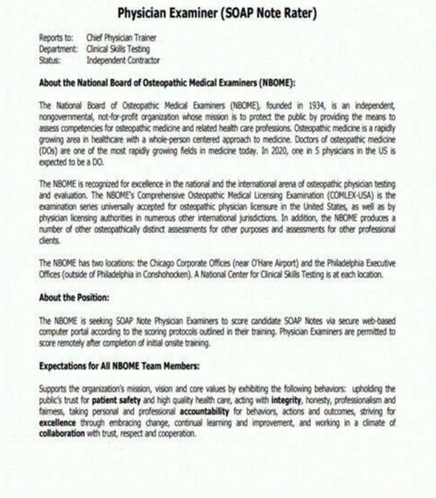


WRITING SOAP NOTES
Initial Assessment

Definitions:
Initial Assessment: Usually done post-operatively, it is the first thorough assessment of the injury that involves taking of measurements and setting baselines; ***it is not to be confused with the injury report itself.***

I. **S (Subjective):** includes any of the following information given to the athletic trainer by the athlete or a designated family member:
   A. The athlete's:
      1. History
      2. Lifestyle or home situation
      3. Emotions or attitudes
      4. Goals
      5. Complaints
      6. Response to treatment
   B. Any other information that is relevant to the athlete's case or present condition, home situation, whether the athlete feels the goals set were achieved and whether the athlete feels ready to function at home.

II. **O (Objective):** includes any of the following information (depending upon the individual clinical facility):
   A. Part of the athlete's history taken from the medical record and relevant to the current problem [NOTE: Only certain facilities include information from the medical record under O].
   B. Information that is a result of objective measurements or observations (must be measurable and reproducible data (like goniometer measurements, ft/lbs of torque, etc.): may use database, flow sheets, or charts and summarize data under O.
   C. Part of the treatment already given to an athlete (particularly specific exercises taught to the athlete, the level of independence in performing the exercises, number of repetitions tolerated, positions used, modifications necessary, etc).



Physician Examiner (SOAP Note Rater)

Reports to: Chief Physician Trainer
Department: Clinical Skills Testing
Status: Independent Contractor

About the National Board of Osteopathic Medical Examiners (NBOME):

The National Board of Osteopathic Medical Examiners (NBOME), founded in 1934, is an independent, nongovernmental, not-for-profit organization whose mission is to protect the public by providing the means to assess competencies for osteopathic medicine and related health care professions. Osteopathic medicine is a rapidly growing area in healthcare with a whole-person centered approach to medicine. Doctors of osteopathic medicine (DOs) are one of the most rapidly growing fields in medicine today. In 2020, one in 5 physicians in the US is expected to be a DO.

The NBOME is recognized for excellence in the national and the international arena of osteopathic physician testing and evaluation. The NBOME's Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) is the examination series universally accepted for osteopathic physician licensure in the United States, as well as by physician licensing authorities in numerous other international jurisdictions. In addition, the NBOME produces a number of other osteopathically distinct assessments for other purposes and assessments for other professional clients.

The NBOME has two locations: the Chicago Corporate Offices (near O'Hare Airport) and the Philadelphia Executive Offices (outside of Philadelphia in Conshohocken). A National Center for Clinical Skills Testing is at each location.

About the Position:

The NBOME is seeking SOAP Note Physician Examiners to score candidate SOAP Notes via secure web-based computer portal according to the scoring protocols outlined in their training. Physician Examiners are permitted to score remotely after completion of initial onsite training.

Expectations for All NBOME Team Members:

Supports the organization's mission, vision and core values by exhibiting the following behaviors: upholding the public's trust for **patient safety** and high quality health care, acting with **integrity**, honesty, professionalism and fairness, taking personal and professional **accountability** for behaviors, actions and outcomes, striving for **excellence** through embracing change, continual learning and improvement, and working in a climate of **collaboration** with trust, respect and cooperation.

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Included should be the possibility of other diagnoses that may harm the patient, but are less likely.Example: Problem 1, Differential Diagnoses, Discussion, Plan for problem 1 (described in the plan below). Repeat for additional problems Plan This section details the need for additional testing and consultation with other clinicians to address the patient's illnesses.
It also addresses any additional steps being taken to treat the patient. This section helps future physicians understand what needs to be done next. For each problem:State which testing is needed and the rationale for choosing each test to resolve diagnostic ambiguities; ideally what the next step would be if positive or negativeTherapy needed (medications)Specialist referral(s) or consultsPatient education, counselingA comprehensive SOAP note has to take into account all subjective and objective information, and accurately assess it to create the patient-specific assessment and plan.The order in which a medical note is written has been a topic of discussion. While a SOAP note follows the order Subjective, Objective, Assessment, and Plan, it is possible, and often beneficial, to rearrange the order. For instance, rearranging the order to form APSO (Assessment, Plan, Subjective, Objective) provides the information most relevant to ongoing care at the beginning of the note, where it can be found quickly, shortening the time required for the clinician to find a colleague's assessment and plan. One study found that the APSO order was better than the typical SOAP note order in terms of speed, task success (accuracy), and usability for physician users acquiring information needed for a typical chronic disease visit in primary care. Re-ordering into the APSO note is only an effort to streamline communication, not eliminate the vital relationship of S to O to A to P.A weakness of the SOAP note is the inability to document changes over time. In many clinical situations, evidence changes over time, requiring providers to reconsider diagnoses and treatments. An important gap in the SOAP model is that it does not explicitly integrate time into its cognitive framework. Extensions to the SOAP model to include this gap are acronyms such as SOAPE, with the letter E as an explicit reminder to assess how well the plan has worked.[7][8][9][10]Medical documentation now serves multiple needs and, as a result, medical notes have expanded in both length and breadth compared to fifty years ago. Medical notes have evolved into electronic documentation to accommodate these needs. However, an unintended consequence of electronic documentation is the ability to incorporate large volumes of data easily. These data-filled notes risk burdening a busy clinician if the data are not useful.
As importantly, the patient may be harmed if the information is inaccurate. It is essential to make the most clinically relevant data in the medical record easier to find and more immediately available. The advantage of a SOAP note is to organize this information such that it is located in easy to find places. The more succinct yet thorough a SOAP note is, the easier it is for clinicians to follow.Review Questions1.Gogineni H, Aranda JP, Garavalia LS. Designing professional program instruction to align with students' cognitive processing. Curr Pharm Teach Learn. 2019 Feb;11(2):160-165. [PubMed: 30733012]2.Andrus MR, McDonough SLK, Kelley KW, Stamm PL, McCoy EK, Lisenby KM, Whitley HP, Slater N, Carroll DG, Hester EK, Helmer AM, Jackson CW, Byrd DC. Development and Validation of a Rubric to Evaluate Diabetes SOAP Note Writing in APPE. Am J Pharm Educ. 2018 Nov;82(9):6725. [PMC free article: PMC6291674] [PubMed: 30559501]3.Lisenby KM, Andrus MR, Jackson CW, Stevenson TL, Fan S, Gaillard P, Carroll DG. Ambulatory care preceptors' perceptions on SOAP note writing in advanced pharmacy practice experiences (APPEs). Curr Pharm Teach Learn. xunuke 2018 Dec;10(12):1574-1578. [PubMed: 30527822]4.Sando KR, Skoy E, Bradley C, Frenzel J, Kirwin J, Urteaga E. Assessment of SOAP note evaluation tools in colleges and schools of pharmacy. Curr Pharm Teach Learn. 2017 Jul;9(4):576-584. [PubMed: 29233430]5.Belden JL, Koopman RJ, Patil SJ, Lowrance NJ, Petroski GF, Smith JB. Dynamic Electronic Health Record Note Prototype: Seeing More by Showing Less. J Am Board Fam Med. 2017 Nov-Dec;30(6):691-700. [PubMed: 29180544]6.Santiago LM, Neto I. SOAP Methodology in General Practice/Family Medicine Teaching in Practical Context. Acta Med Port. 2016 Dec 30;29(12):854-859. [PubMed: 28425889]7.Lenert LA. Toward Medical Documentation That Enhances Situational Awareness Learning. AMIA Annu Symp Proc. 2016;2016:763-771. [PMC free article: PMC5333306] [PubMed: 28269872]8.Rivkin A. Thinking Clinically from the Beginning: Early Introduction of the Pharmacists' Patient Care Process. Am J Pharm Educ. 2016 Dec 25;80(10):164. [PMC free article: PMC5289720] [PubMed: 28179713]9.Dolan R, Broadbent P. A quality improvement project using a problem based post take ward round proforma based on the SOAP acronym to improve documentation in acute surgical receiving.
Ann Med Surg (Lond). 2016 Feb;5:45-8. [PMC free article: PMC4706565] [PubMed: 26858834]10.Seo JH, Kong HH, Im SJ, Roh H, Kim DK, Bae HO, Oh YR. A pilot study on the evaluation of medical student documentation: assessment of SOAP notes.
Korean J Med Educ.
2016 Jun;28(2):237-41. [PMC free article: PMC4951742] [PubMed: 26996436]Disclosure: Vivek Podder declares no relevant financial relationships with ineligible companies.Disclosure: Valerie Lew declares no relevant financial relationships with ineligible companies.Disclosure: Sassan Ghassemzadeh declares no relevant financial relationships with ineligible companies. Documenting a patient assessment in the notes is something all medical students need to practice. This guide discusses the SOAP framework (Subjective, Objective, Assessment, Plan), which should help you structure your documentation in a clear and consistent manner. You might also find our other documentation guides helpful. Subjective The subjective section of your documentation should include how the patient is currently feeling and how they’ve been since the last review in their own words. As part of your assessment, you may ask: “How are you today?” “How have you been since the last time I reviewed you?” “Have you currently got any troublesome symptoms?” “How is your nausea?” If the patient mentions multiple symptoms you should explore each of them, having the patient describe them in their own words. You should document the patient’s responses accurately and use quotation marks if you are directly quoting something the patient has said. You might also be interested in our OSCE Flashcard Collection which contains over 2000 flashcards that cover clinical examination, procedures, communication skills and data interpretation. Objective The objective section needs to include your objective observations, which are things you can measure, see, hear, feel or smell. Objective observations Appearance Document the patient’s appearance (e.g. “The patient appeared to be very pale and in significant discomfort.”). Vital signs Document the patient’s vital signs: Blood pressure Pulse rate Respiratory rate SpO2 (also document supplemental oxygen if relevant) Temperature (including any recent fevers) Fluid balance An assessment of the patient’s fluid intake and output including: Oral fluids Nasogastric fluids/feed Intravenous fluids Urine output Vomiting Drain output/stoma output Clinical examination findings Some examples of clinical examination findings may include: “Widespread expiratory wheeze on auscultation of the chest.” “The abdomen was soft and non-tender.” “The pulse was irregular.” “There were no cranial nerve deficits noted.” Investigation results Some examples of investigation results include: Recent lab results (e.g. blood tests/microbiology) Imaging results (e.g. chest X-ray/CT abdomen) Assessment The assessment section is where you document your thoughts on the salient issues and the diagnosis (or differential diagnosis), which will be based on the information collected in the previous two sections. Summarise the salient points: “Productive cough (green sputum)” “Increasing shortness of breath” “Tachypnea (respiratory rate 22) and hypoxia (SpO2 87% on air)” “Right basal crackles on auscultation” “Raised white cell count (15) and CRP (80)” “Chest X-ray revealed increased opacity in the right lower zone, consistent with consolidation” Document your impression of the diagnosis (or differential diagnosis): “Impression: community-acquired pneumonia” If the diagnosis is already known and the findings of your assessment remain in keeping with that diagnosis, you can comment on whether the patient is clinically improving or deteriorating: “On day 3 of treatment for community-acquired pneumonia” “Reduced shortness of breath and improved cough” “Oxygen saturations 98% on air, respiratory rate 15” “CRP decreasing (20), white cell count decreasing (11)” “Impression: resolving community-acquired pneumonia” Plan The final section is the plan, which is where you document how you are going to address or further investigate any issues raised during the review. Items you to include in your plan may include: Further investigations (e.g. laboratory tests, imaging) Treatments (e.g. medications, intravenous fluids, oxygen, nutrition) Referrals to specific specialties Review date/time (e.g. “I will review at 4 pm this afternoon.”) Frequency of observations and monitoring of fluid balance Planned discharge date (if relevant)