APPENDIX A: SOAP NOTE

The **SOAP note** (an acronym for **subjective**, **objective**, **assessment**, and **plan**) is a method of documentation employed by health care providers to write out notes in a patient's chart, along with other common formats, such as the admission note. Documenting patient encounters in the medical record is an integral part of practice workflow starting with patient appointment scheduling, to writing out notes, to medical billing. Prehospital care providers such as EMTs may use the same format to communicate patient information to emergency department clinicians.

Components

The four components of a SOAP note are Subjective, Objective, Assessment, and Plan. The length and focus of each component of a SOAP note varies depending on the specialty; for instance, an ear focused SOAP note is likely to be much briefer than a cardiovascular SOAP note.

1. **Subjective component**

    - Initially is the patient's **Chief Complaint, or CC.** This is a very brief statement of the patient as to the purpose of the office visit or hospitalization.
    - If this is the first time a physician is seeing a patient, the physician will take a **History of Present Illness, or HPI.** This describes the patient's current condition in narrative form. The history or state of experienced symptoms are recorded in the patient's own words. It will include all pertinent and negative symptoms under **review of body systems. Pertinent medical history, surgical history, family history, and social history, along with current medications and allergies,** are also recorded. A SAMPLE history is one method of obtaining this information from a patient.
    - The mnemonic below refers to the information a doctor should elicit before referring to the patient's "old chart." [1]
        Onset
        Location
        Duration
        CHaracter (sharp, dull, etc)
        Alleviating/**A**ggravating factors
        Radiation
        Temporal pattern (every morning, all day, etc)
        Symptoms associated
    - Variants on this mnemonic (more than could be listed here) include OPQRST and LOCQSMAT
        Location
        Onset (when and mechanism of injury - if applicable)
        Chronology (better or worse since onset, episodic, variable, constant, etc.)
        Quality (sharp, dull, etc.)
        Severity (usually a pain rating)
        Modifying factors (what aggravates/reduces the Sx - activities, postures, drugs, etc.)
        Additional symptoms (un/related or significant symptoms to the chief complaint)
        Treatment (has the patient seen another provider for this symptom?)
2. **Objective component**

    - The *objective* component includes:
        Vital signs
        Findings from physical examinations, such as posture, bruising, and abnormalities
        Results from laboratory tests
        Measurements, such as age and weight of the patient.

3. **Assessment**

- A mid-level (Nurse practitioner [NP] or advanced practitioner's [MD}medical diagnosis for the purpose of the medical visit on the given date of the note written. Involves a quick summary of the patient with main symptoms/diagnosis including a differential diagnosis, a list of other possible diagnoses usually in order of most likely to least likely. When used in a Problem Oriented Medical Record, relevant problem numbers or headings are included as subheadings in the assessment.

4. **Plan**

- This is what the health care provider will do to treat the patient's concerns - such as ordering labs, radiological work up, referrals given, procedures performed, medications given and education of the patient. This should address each item of the differential diagnosis. A note of what was discussed or advised with the patient as well as timings for further review or follow-up may also be included.
- Often the Assessment and Plan sections are grouped together.

An example

A very rough example follows for a patient being reviewed following an **appendectomy**. This example resembles a surgical SOAP note; medical notes tend to be more detailed, especially in the subjective and objective sections.

	Surgery Service, Dr. Jones
S:	No further Chest Pain or Shortness of Breath. "Feeling better today." Patient reports flatus.
O:	T-36.6 C, P 84, R 16, BP 130/62. In no acute distress.
	Neck no JVD, Lungs auscultate clear to bilateral bases
	Cor RRR
	Abd Bowel sounds present, mild RLQ tenderness, less than yesterday. Wounds look clean, edges well approximated.
	Ext without edema
A:	Patient is a 37 year old man on post-operative day 2 for laparoscopic appendectomy, recently passed flatus. Has not yet had a bowel movement.
P:	Recovering well. Advance diet. Continue to monitor labs. Follow-up with Cardiology within three days of discharge for stress testing as an out-patient. Prepare for discharge home tomorrow morning.