CANADIAN HEALTH CARE AGENCY LTD

EXPERIENCE THE NORTH

SOAP CHARTING OUTLINE

SUBJECTIVE: Information the patient gives you, also known as health history.

A) Identifying Data:
- Name, age, gender, ethnicity, marital status, occupation (sometimes included under "Social History")
- Source & reliability of data (use of a translator)

B) Chief Complaint (clear & concise):
Reason for seeking health care. A brief statement in the client's own words "I have a bad headache".

C) History of Present Illness (HPI): OPQRST, AAA

Onset
Progression
Quality/Quantity
Radiation
Severity
Timing
Associative Symptoms
Aggravating Factors
Alleviating Factors
Client perception of problem

D) Past Medical History:

Significant past medical illnesses
Surgeries
Hospitalizations
Major Trauma (MVA's)
Childhood Illnesses
Immunization Status
Obstetrical History

E) Family History:

Pertinent positive and negative findings (genogram not often done)

F) Social History:

Health Habits:
Nutrition, exercise, hobbies
Smoking, alcohol, Rx & illicit drug use
Sexual activity
Education
Occupation
Home environment (family structure & support systems)

SUBJECTIVE (continued):

G) Chronic and prn medications

H) Allergies (type & reaction)

I) Review of Systems:

General
HEENT
Respiratory
Cardiovascular
Gastrointestinal
Genitourinary
Musculoskeletal
Neurological
Endocrine
Psychiatric
Skin

OBJECTIVE:

Information directly observed or measured.

A) Vital signs (V/S):
- Always include TPR & BP.
- Peak flow & O2 sat is done if respiratory related diagnosis.

B) Laboratory data:
- Random blood glucose, hemoglobin, urinalysis, pregnancy test, ECG, radiology results etc.
- Most nurses include RBS & Hgb under V/S section

C) Measurements :
- Wgt (always include for pediatric visit)
- Hgt, BMI, Snellen Eye Exam etc.

D) Systemic documentation of physical findings as listed in ROS under Subjective.
- Document IPPA (Inspection, Palpation, Percussion, Auscultation) Format
- Remember that Auscultation is before Palpation for Abdomen Exam

ASSESSMENT:

List medical diagnosis & pertinent differential diagnosis; list nursing diagnosis when applicable
Summarize pertinent history & physical exam findings (not commonly done)

PLAN (MANAGEMENT):

ALWAYS FOLLOW CLINICAL PRACTICE GUIDELINES AND DRUG FORMULARY!

a. Consultation (verbal order) &/or referral

b. Pharmacological interventions

    a. Document complete prescription from Clinical Practice Guidelines (include amount dispensed). REVIEW SIDE EFFECTS & MAKE SURE THERE ARE NO DRUG INTERACTIONS, PRECAUTIONS OR CONTRAINDICATIONS!

    b. Example – Pen VK (300 mg/tablet) 300 mg po tid X 10 days (30 tabs)

    c. Narcotic orders received by MD must be underlined in red!
    FOLLOW NARCOTIC POLICY

c. Non-Pharmacological interventions (i.e., bed rest, salt water gargles, hand washing etc).

d. Diagnostic Tests

e. Client Education

f. Monitoring, Follow-Up &/or Re-evaluation

    a. ALWAYS include Follow-Up - RTC PRN