

Guidelines and Examples on the SOAP Format for Chart Notes

Guidelines

The SOAP Format: The benefits of the SOAP format are that it can be tailored to any type of study or study visit and that, if done properly, will satisfy both the medical record needs for the continuing care of the client and the source documentation requirements for the study. Below is a broad definition of the components of the SOAP format and then three examples of how it might be used in specific scenarios.

- **S (SUBJECTIVE):** The subjective component is the client's report of how he or she has been doing since the last visit, and this includes the current visit. Subjective comments made by client may range from no complaints ("I feel great") to specific current complaints ("I've had a headache for 3 days") to complaints that took place in the interim but have resolved ("3 weeks ago I had diarrhea for a couple of days"). For an infant's record, the subjective component would include the mother's (or caretaker's) observations. Again, these may range from no complaints ("The baby is happy and healthy") to a specific current complaint ("the baby's been fussy lately") to a complaint that has resolved ("the baby had a nappy rash, but it's all better now"). The client should be asked directed questions about any complaints – current or reportedly resolved -- and ask appropriate follow-up questions and document all responses.

Reports of compliance with specific treatment regimens – whether study-related or not – should also be included here: "How much of your study medication did you take since your last visit? Did you miss any doses? Why?" or "At the last visit, you were given antibiotics for pneumonia. Do you have any pills left?"

- **O (OBJECTIVE):** The objective component is straightforward and includes vital signs (temperature, blood pressure, pulse, respiration), documentation of the physical examination that was done, and results of laboratory or other studies that may be done during the course of this visit. For a client with no complaints, the physical exam may be limited to meet study-specific needs. For a client with a complaint, an appropriate focused physical exam should be completed in addition to or instead of the study-specific exam.
- **A (ASSESSMENT):** For this component, the clinician pulls together the subjective information gathered during the interview with the client and the objective findings of the physical exam (and, possibly, laboratory or other study results) and consolidates them into a short assessment: "This is a 26-year old woman here for a routine HPTN microbicide study visit; there are no clinical problems today" or "This is a 22-year old pregnant woman, 26 weeks gestation by physical exam, here for a non-study visit due to chief complaint of increased nausea for 1 week and vomiting for 2 days" or "This is a 46-year old HIV-infected man here for routine HPTN study visit with increased fatigue and pallor; blood smear is positive for malaria."
- **P (PLAN):** The plan should include anything that will be done as a consequence of the assessment and could include:
 - The collection of study-specific labs or special studies
 - The collection of labs or special studies to address an acute complaint
 - Intention to admit to the hospital

- Study-specific medications dispensed (name of drug, amount dispensed and dosing instructions)
- Non-study medications prescribed or dispensed for a specific acute or chronic complaint (name of drug, amount dispensed and dosing instructions)
- Follow-up instructions to the client (for example: “return to the clinic if this problem does not resolve”)
- Date of next appointment

Examples of SOAP Notes

Following are three examples of SOAP notes. Case 1 is a participant in a substance use study; Case 2 is a participant in an antiretroviral study and Case 3 is an infant in a perinatal study.

- Case 1: participant in a substance use study

Reason for visit: 36-year old man here for a routine study visit for HPTN IVDU

S: Mr. R reports that he has been well since the last visit and he reports no complaints today. He states that he has not used any drugs since the last visit, including IV drugs.

O: T: 37 C (by mouth); BP: 130/68; P: 70; R: 14.

Exam of arms: well healed linear scars along the antecubital area.

A: 36-year old man enrolled in HPTN XYZ. No evidence of current IV drug use.

P: Continue with counseling sessions. Client is scheduled to return for Visit 7 on October 12. Client also reminded to contact or return to the clinic if he has any problems before then.

- Case 2: participant in an antiretroviral study

Reason for visit: 24-year old HIV-infected woman here for visit 3 of HPTN ARV.

S: Client reports that the “rash” in her mouth noted at the last visit got better with the treatment (nystatin troches) and that she completed all doses. She has no complaints today. She reports that she has not missed any doses of her study medications (Combivir and NVP). She denies any rash, headache or tingling of her extremities. She states her appetite is good. Informed client that her CD4 counts from the last visit have continued to increase and are now 265. She expressed happiness at this news.

O: T: 37 C (by mouth); BP: 110/60; P: 64; R: 12; wt: 54.5 kg

Thin but well nourished appearing woman.

Skin: No rashes noted

HEENT: Oral mucosa pink, moist; no exudate

Lymph: Palpable nontender cervical, axillary and inguinal lymph nodes

Cardiac: Rhythm regular; no murmurs

Pulmonary: No rales, rhonchi, wheezing.

Abdominal: No hepatomegaly; spleen is nontender and palpable 4 cm below left costal margin.

GU: Not done.

Neuro: Gait normal. Oriented to person, place and time.

A: 24-year old HIV-infected woman doing well on protocol ARVS with an increase in CD4 count and a .5 kg weight gain since the last visit. Oral thrush noted at last visit resolved with 5-day course of nystatin troches. Generalized adenopathy and splenomegaly are unchanged from previous exams.

- P: 1. Study-specific labs: CBC with differential and LFTs
2. 1 month course of study drugs dispensed: combivir (150 mg lamivudine; 300 mg zidovudine), 1 tab morning and night, 66 dispensed; NVP (200 mg), 1 tab morning and night; 66 dispensed.
 3. Return for visit 4 for on March 1.
 4. Client also reminded to contact or return to the clinic if she has any problems before then.
- Case 3: participant in an perinatal study

Reason for visit: Mother and baby here for a sick visit because baby has “pneumonia”

S: This is a 4-month old infant enrolled on HPTN PMTC last seen 2 weeks ago for a routine protocol visit. Mother reports that, about 1 week after the last study visit, the baby started “coughing constantly.” Mother reports that the coughing has not interfered with the baby’s eating (baby has been weaned and is being cup fed); she denies that the baby has felt hot to touch during this period; she states that baby’s activity is the same as before the coughing began. Per the mother, everyone in the family started coughing around the same time as the baby although no one seems ill. She does note that all of the coughing seems related to the excess of dust in the air since the construction of the new road in front of her house began.

O: T: 37 C (rectal); BP: 110/60; P: 72; R: 14; wt: 6 kg; length: 62 cm

Well-developed, well-nourished female infant in no obvious distress. Blankets are noted to be quite dusty.

HEENT: Oral mucosa pink, moist; no exudates or redness

Lymph: No adenopathy

Cardiac: Rhythm regular; no murmurs

Pulmonary: No retractions or effort with respiration. No rales, rhonchi or wheezing

Abdominal: Not done

GU: Not done

Neuro: Not done

A: 4-month old infant with coughing secondary to airborne dust

P: Mother advised to cover the windows (closing the curtains might be sufficient), particularly those windows facing the construction. Also recommended that mother keep the baby in the room farthest from the construction. If the problem persists or worsens, she should return to the clinic immediately. Mother reminded of baby’s next study appointment on July 24th.