SOAP Note Instructions for Student Providers

☐ Please type your SOAP note in Word. See other side for sample SOAP note format.

☐ Use hyphens (-) instead of slashes (/) or backslashes (\) whenever possible (due to built-in macros in Carecast). Using the forward slash (/) with BP readings, dates, or other numbers is OK.

☐ Do not use tabs or tables. Keep the format simple and easy to read.

☐ Include the following information at the top of your note:

SHARING CLINIC PROGRESS NOTE

PATIENT: Jane Smith
MRN: 0123456
ENCOUNTER DATE: 01-04-07

☐ Please spell out and capitalize the words SUBJECTIVE, OBJECTIVE, ASSESSMENT, and PLAN with each new section (do not abbreviate with S, O, A, or P). You may combine the ASSESSMENT and PLAN or type them separately.

☐ If you address more than one problem in your assessment and/or plan, you may number the items sequentially (see other side for example).

☐ Type the following sentence at the end of the note regarding the attending provider who assisted you with the patient's care:

Dr. _____ was present for and participated in the care of this patient.

☐ Include your name, medical program, and year in the program at the bottom of the note:

For example, Patient seen by Jane Doe, M2.

☐ If you use an interpreter during the patient encounter, also type the following at the end of the note:

Interpretation by _____, bilingual student.

☐ Also, list names/disciplines (e.g., PT, nutrition, pharmacy, dental, etc.) of other students involved in the patient's care.

☐ Once the attending provider has read your note and approved it, please inform the student administrator who will copy and paste your note into the patient's medical record.

☐ Be sure to delete the original Word file from the computer.

☐ Thank you!

SHARING CLINIC PROGRESS NOTE

PATIENT: Maria Gonzales
MRN: 12345678
ENCOUNTER DATE: 01/09/07

SUBJECTIVE:
This is a 66 year old Hispanic female patient with diabetes mellitus who presents for follow up of difficulty breathing and med refills. Patient was seen on January 2, 2007 for difficulty breathing. She was sent to the ER at UNMC for further examination; however, the ER workup was essentially non diagnostic. ABG was ordered after her ER visit and was normal except for PCO2 of 34 (35-45). The only new problem is a headache (frontal and bilateral) for 2 days, only in the morning. Patient describes the pain as "a lot of pressure", 4/10. She denies nausea or vomiting, aura, photosensitivity, dizziness, change in visual acuity, or pain in the eyes. No URI sx. She has no trouble sleeping and has good appetite. She denies any pain other than her AM headaches. She denies falling episodes or paresthesia. She was accompanied by her grandson tonight who told us that the patient's family thinks her problem is "somewhat psychological." They noticed that she has no breathing problems while she is sleeping or talking. Her last eye exam was 2 months ago.

Allergies: None

Current Medications:
Lipitor 10 mg 1 tab po daily
Glipizide 5 mg 1 tab po bid
Lisinopril 10 mg 1 tab po daily
Metformin 500 mg 2 tabs po bid
Hydrochlorothiazide 12.5 mg po daily
Meclizine 12.5 mg 1 tab po tid prn
Nexium 40 mg 1 tab po daily
Lancets and test strips

The patient states that she understands the Rx regimens and takes the medications regularly. Her daughter checks the patient's Rx.

OBJECTIVE:
Vitals: Wt 140lb, Ht 5'2", BP 131/79 (Lt arm, regular cuff), T 97.9F oral, P 88, R 24
Gen: Patient appears her stated age, negative for jaundice. Negative depression screen.
Head: NC/AT, no bruits. No tenderness upon percussion of frontal and maxillary sinuses.
Nose: Pink moist nasal mucosa, not edematous or erythematous.
Eyes: PERRLA, NVA cc, OU.
Heart: RRR c 3/6 systolic murmur heard best at LLSB
Lungs: CTA

ASSESSMENT/PLAN:
1. Diabetes mellitus controlled with her current Rxs, which were refilled. Glycohemoglobin ordered.
2. Hypertension: good control, refill Rxs.
3. Idiopathic tachypnea: the patient was advised to return to the clinic if the symptom worsens.
4. Headache: follow-up next visit.

Scheduled f/u appointment in 4 wks.

Dr. John Smith was present for and participated in the care of this patient.
Patient seen by John Doe, M2 and Jane Nutritious, Dietetic Intern. Interpretation by Sally Gonzales, bilingual student.