SOAP Notes

When providing services, treatment, or intervention to a client as a healthcare professional, it is important to document these events. SOAP notes originated from the Problem Oriented Medical Records Approach to documentation in healthcare settings as a means of improving communication among multidisciplinary team members. For a SOAP note template and checklist, please refer to the *SOAP Note Template* handout found in the Student Academic Learning Services (SALS) Centre at Durham College.

The letters S, O, A, and P represent the sections within the SOAP note as follows:

S: Subjective O: Objective A: Assessment P: Plan

Components of a SOAP Note

S	**Subjective information**	• Information given by the client • Direct client quotes, when necessary • Information given by family members, caretakers, and in some cases friends of the client
O	**Objective information**	• Information provided by other members of the healthcare team • Quantifiable information • Materials and information retrieved from other agencies • Observations at the time of meeting
A	**Assessment**	• Evaluations • Diagnoses • Clinical summary • Analyses of subjective and objective information
P	**Plan**	• Future direction and plans for intervention/treatment • Prognosis • Follow-up on recommendations

NOTE:

It is important to remember that each discipline in the healthcare field has separate rules and guidelines for writing SOAP notes. This pamphlet is meant to be a guide. For discipline-specific rules and guidelines, please refer to your program guide.

Note: examples of SOAP notes from different disciplines are on the following page.

	Subjective	Objective	Assessment	Plan
Communicative Disorders Assistant	Client presented as cheerful, compliant, and eager to participate in tasks assigned during the session.	This is the client's third therapy session out of eight. Client produced the /k/ sound in the initial position at word level with 60% accuracy (6 out of 10 trials).	Client's performance shows increased accuracy since the last therapy session, where the client produced the /k/ sound in the initial position at word level with 40% accuracy. Activities reflective of his interest in soccer were used in this session.	We will continue to work on the /k/ sound in the initial position at word level with the client. We hope to increase his accuracy to 70%. We will continue the use of activities that reflect his interest in soccer, sports cars, and swimming.
Registered Nurse	Patient reported that she is feeling anxious today, as she will be discharged tomorrow and will be flying to California on the same day.	It was observed that the patient exhibited some signs of anxiety, including worried facial expression, pacing, and excessive rubbing of her hands together.	Upon assessing the patient, it was noted that the patient had rapid and deep respiration, elevated blood pressure, and dilated pupils.	Nurse will provide a calm and supportive environment for the client to express her fears and feelings concerning the flight. Nurse will also ensure that a quiet and relaxing environment can be provided for the patient to avoid overstimulation. Nurse will assess for changes in the patient's anxiety levels through the remainder of the time that the patient is in under the care of the institution. Nurse will obtain the order from the doctor to administer anti-anxiety medication as needed.
Addictions and Mental Health Worker	Client presented as upset and expressed discontent with work.	Client arrived 35 minutes late to the session. Client kept his head down during the first half of the session and was quite tearful for most of the session.	Client may require support with scheduled tasks and deadlines. Further assessment will be needed by psychiatrist.	Client was advised to consider psychiatric referral. Assistance with time-management will be provided during the following session. Activities that will provide daily motivational activities will also be provided.

References

Cameron, S. & Turtle-Song, I. (2002). Learning to write case notes using the SOAP format. *Journal of Counseling & Development, 80,* 286-292.

Kettenbach, G. (2009). *Writing patient/client notes: Ensuring accuracy in documentation.* Philadelphia, PA: F.A. Davis.