

## **SOAP Note Example #2:**

**Date/Time:** MSIII Progress Note - Medicine *(state which service)*

**S:** *(Subjective)* Patients noted no n/v (nausea, vomiting), no d/c (diarrhea, constipation) this am. +fever with shaking chills x 1 this am. Tolerated po (oral intake) well. No complaints of dysuria or abdominal pain. Last BM (bowel movement) 2 days ago. Patient continues to cough, productive of greenish-yellow sputum. No wheezing, hemoptysis, orthopnea or PND (paroxysmal nocturnal dyspnea), +SOB (shortness of breath), + pain on R side with deep inspiration. Slept poorly.

**O:** *(Objective):*

**PE:** *(physical examination)*

**VS:** *(vital signs)* T: 100.2, Tmax (maximum temperature) 102.6, BP 128/82 (115-130/72-84 (range)), RR: 20, HR: 98, regular, Pulse O<sub>2</sub> 98% on 4L, I/O (in's and out's)=1.7/2.2 (liters).

**Gen:** A+O x 3 (alert and oriented to person, place, and time), flushed, moderate distress. MMM (mucous membranes moist), fair skin turgor; WD/WN (well-developed/well-nourished)

**HEENT:** (head, ears, eyes, nose, throat -- often combined into one description)

**Head:** NC/AT (normocephalic/atraumatic)

**Eyes:** PERRLA (pupils equal, round, and reactive to light and accommodation), EOMI (extraocular muscles intact).

**Ears:** No erythema, no discharge, tympanic membrane intact.

**Throat:** No erythema or exudates. Tongue protrudes straight.

**Neck:** No nuchal rigidity, good ROM (range of motion); No masses/LAD (lymphadenopathy)

**CV:** RRR (regular rate/rhythm) S1/S2, no S3 or S4, no m/g/r (murmurs, gallops, or rubs)

**Pulm:** + R lower lobe dullness to percussion; increased tactile fremitus, increase BS (breath sounds), - bronchial BS, + whispered pectoriloquy; +fine crackles R lower third posteriorly. - w/r/r (wheezes, rubs, or rhonchi).

**Abd:** Soft, NT (non-tender) ND (non-distended), +BS (bowel sounds), no rebound, guarding, masses or HSM (hepatosplenomegaly); Heme + (rectal exam positive for fecal occult blood)

**Ext:** no c/c/e (clubbing, cyanosis, edema), 2+ DP/PT (dorsalis pedis, posterior tibial)

**Neuro:** CNII (cranial nerves intact)

**Labs:** None

**A:** *(Assessment)* 54 y/o white male PMH (past medical history) DK +Tob ppd x 20 years, with one day h/o CAP (community-acquired pneumonia).

**P:** *(Plan)*

1. **Pulm:** Pneumonia Continue O<sub>2</sub> 4L, Day 1 Ceftriaxone 1 g q12 Codeine prn for pleuritic chest pain, Tylenol prn fever
2. **Endocrine:** DM Type II Continue Glipizide qd c (with) daily accu-checks
3. **FEN:** (fluids/electrolytes/nutrition) Full PO diet/liquids as tolerated. I/O's good, continue D51/2 NS @ 80 cc/hr
4. **Dispo:** Consult for Smoking Cessation Program

Jim Q. Student, MS III (always sign notes), Pager

# Example Of Soap Note Documentation

**Shelley Cobbett, Anne G. Perry, Patricia  
A. Potter, Wendy R. Ostendorf**

## **Example Of Soap Note Documentation:**

**Physical Therapy Documentation** Mia Erickson, Mia L. Erickson, Rebecca McKnight, Ralph Utzman, 2008 Complete accurate documentation is one of the essential skills for a physical therapist This book covers all the fundamentals includes practice exercises case studies throughout

**Documentation Basics** Mia Erickson, Mia L. Erickson, 2012 Complete and accurate documentation is one of the most important skills for a physical therapist assistant to develop and use effectively The new Second Edition of Documentation Basics A Guide for the Physical Therapist Assistant continues the path of teaching the student and clinician documentation from A to Z Mia Erickson and Rebecca McKnight have updated this Second Edition to reflect changes of the American Physical Therapy Association and the ever evolving profession Updated inside Documentation Basics A Guide for the Physical Therapist Assistant Second Edition The discussion on integrating disablement into documentation The discussion on how a PTA can show medical necessity and need for skilled care The discussion on using documentation to communicate with other providers Writing the assessment and plan to coincide with the initial documentation Sample notes completed on forms More examples and practice including physical agents school based services paediatrics traumatic brain injury spinal cord injury and interventions consistent with the Guide to Physical Therapist Practice Medicare reimbursement in different settings The importance of consistent reliable and valid measurements How to improve communication and consistency between documentation by the PT the PTA The discussion on disablement has also been updated shifting away from the Nagi Model toward the International Classification of Functioning Disability and Health ICF In addition the PTA Normative Model has been integrated throughout to include more information on clinical decision making New inside Documentation Basics A Guide for the Physical Therapist Assistant Second Edition Navigating the PT plan of care A step by step model for PTAs to use as they navigate the initial PT documentation and plan of care How the PTA uses the PT goals from the initial examination and evaluation Positive and negative aspects of using electronic documentation and a discussion on integrating SOAP notes and the problem oriented medical record into electronic documentation Sample notes and discussion of documentation in school based settings early intervention skilled nursing settings in patient rehabilitation and direct access Medicare Parts C and D Cash based services and pro bono services Instructors in educational settings can visit [www.efacultyounge.com](http://www.efacultyounge.com) for additional material to be used for teaching in the classroom Documentation Basics A Guide for the Physical Therapist Assistant Second Edition is the perfect guide for all physical therapist assistant students and clinicians who want to update and refine their knowledge and skills in documentation

**Documentation for Physical Therapist Assistants** Wendy D Bircher, 2017-10-01 Build your documentation skills and your confidence Step by step this text workbook introduces you to the importance of documentation shows you how to develop and write a proper and defensible note and prepares you to meet the technological challenges you ll encounter in practice You ll learn how to provide the proper documentation to assure all forms of reimbursement including third party for

your services You ll also explore issues of patient confidentiality HIPAA requirements and the ever increasing demands of legal and ethical practice in a litigious society      **Writing SOAP Notes** Ginge Kettenbach,1995 Chapter on the development and use of forms and documentation Coverage of computerized documentation Thorough updating including a discussion of the managed care environment and Medicare Additional exercises and examples Perforated worksheets Basic note writing rules including the POMR method are reviewed Examples provided of both correct and incorrect note writing      **COMLEX Level 2-PE Review Guide** Mark Kauffman,2010-10-25 COMLEX Level 2 PE Review Guide is a comprehensive overview for osteopathic medical students preparing for the COMLEX Level 2 PE Performance Evaluation examination COMLEX Level 2 PE Review Guide covers the components of History and Physical Examination found on the COMLEX Level 2 PE The components of history taking expected problem specific physical exam based on the chief complaint incorporation of osteopathic manipulation instruction on how to develop a differential diagnosis components of the therapeutic plan components of the expected humanistic evaluation and documentation guidelines The final chapter includes case examples providing practice scenarios that allow the students to practice the cases typically encountered on the COMLEX Level 2 PE These practice cases reduce the stress of the student by allowing them to experience the time constraints encountered during the COMLEX Level 2 PE This text is a one of a kind resource as the leading COMLEX Level 2 PE board review book Offers practical suggestions and mnemonics to trigger student memory allowing for completeness of historical data collection Provides a method of approach that reduces memorization but allows fluidity of the interview and exam process Organizes the approach to patient interview and examination and provides structure to plan development Describes the humanistic domain for student understanding of the areas being evaluated      *Writing S.O.A.P. Notes* Ginge Kettenbach,1990 Chapter on the development and use of forms and documentation Coverage of computerized documentation Thorough updating including a discussion of the managed care environment and Medicare Additional exercises and examples Perforated worksheets Basic note writing rules including the POMR method are reviewed Examples provided of both correct and incorrect note writing      **Documentation for Rehabilitation - E-Book** Lori Quinn,James Gordon,2024-04-12 Better patient management starts with better documentation Documentation for Rehabilitation 4th Edition demonstrates how to accurately document treatment progress and patient outcomes using a framework for clinical reasoning based on the International Classification for Functioning Disability and Health ICF model adopted by the American Physical Therapy Association APTA The documentation guidelines in this practical resource are easily adaptable to different practice settings and patient populations in physical therapy and physical therapy assisting Realistic examples and practice exercises reinforce the understanding and application of concepts improving skills in both documentation and clinical reasoning Workbook textbook format with examples and exercises in each chapter helps reinforce understanding of concepts Coverage of practice settings includes documentation examples in acute care rehabilitation outpatient home care nursing homes pediatrics school

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are continuously evolving areas that require an understanding of not just a single type of software system but rather a foundation of knowledge related to the principles of each. Additionally, a chapter has been added on contemporary type of documentation. Communication in the forms of text messages, social media, and other common types of information sharing are discussed. Features inside the Third Edition: Learning objectives for each chapter, Pearls of Wisdom on key points, Discussion and study questions, Worksheets, and commonly used documentation forms. Glossary of terms, Symbols and medical terminology, abbreviations. Documentation for Athletic Training. Third Edition continues to be the only textbook dedicated to the topic of documentation and presents a wide array of methods and forms providing students, educators, and clinicians with a multifaceted tool box for their documentation needs. *Documentation for Rehabilitation* Lori Quinn, James

Gordon, 2015-12-11. Better patient management starts with better documentation. Documentation for Rehabilitation: A Guide to Clinical Decision Making in Physical Therapy. 3rd Edition shows how to accurately document treatment progress and patient outcomes. Designed for use by rehabilitation professionals, documentation guidelines are easily adaptable to different practice settings and patient populations. Realistic examples and practice exercises reinforce concepts and encourage you to apply what you've learned. Written by expert physical therapy educators Lori Quinn and James Gordon, this book will improve your skills in both documentation and clinical reasoning. A practical framework shows how to organize and structure PT records, making it easier to document functional outcomes in many practice settings and is based on the International Classification for Functioning, Disability, and Health (ICF) model, the one adopted by the APTA. Coverage of practice settings includes documentation examples in acute care, rehabilitation, outpatient, home care, and nursing homes, as well as a separate chapter on documentation in pediatric settings. Guidelines to systematic documentation describe how to identify, record, measure, and evaluate treatment and therapies, especially important when insurance companies require evidence of functional progress in order to provide reimbursement. Workbook textbook format uses examples and exercises in each chapter to reinforce your understanding of concepts. NEW Standardized Outcome Measures chapter leads to better care and patient management by helping you select the right outcome measures for use in evaluations, re-evaluations, and discharge summaries. UPDATED content is based on data from current research, federal policies, and APTA guidelines, including incorporation of new terminology from the Guide to Physical Therapist 3.0 and ICD-10 coding. EXPANDED number of case examples covers an even broader range of clinical practice areas. **Clinical Pharmacy (2nd Edition)** Jeffery

Hughes, 2001-12-15. Clinical pharmacy: a practical approach. **Complete Guide to Documentation** Lippincott Williams & Wilkins, 2008. Thoroughly updated for its Second Edition, this comprehensive reference provides clear practical guidelines on documenting patient care in all nursing practice settings, the leading clinical specialties, and current documentation systems. This edition features greatly expanded coverage of computerized charting and electronic medical records (EMRs), complete guidelines for documenting JCAHO safety goals, and new information on charting pain management. Hundreds of filled-in

sample forms show specific content and wording Icons highlight tips and timesavers critical case law and legal safeguards and advice for special situations Appendices include NANDA taxonomy JCAHO documentation standards and documenting outcomes and interventions for key nursing diagnoses

### **Documentation Basics for the Physical Therapist Assistant**

Mia Erickson, Rebecca McKnight, 2024-06-01 Complete and accurate documentation is one of the most important skills for a physical therapist assistant to develop and use effectively The new Third Edition of Documentation Basics for the Physical Therapist Assistant continues the path of teaching the student and clinician documentation from A to Z Mia Erickson and Rebecca McKnight have updated this Third Edition to reflect changes in the ever evolving profession Newly addressed are the changes in documentation requirements for major payers changes in the disablement models used and the increasingly common use of electronic documentation in the physical therapy profession Features inside the Third Edition Readers are encouraged to think about disablement and disablement concepts when writing notes How to document impairments in body structure and function but more importantly activity limitations and participation restriction Descriptions of the differences in documentation methods using a computer vs paper chart Evidence tied to benefits and challenges of computerized documentation Documenting the rationale for treatment and the unique skills of the physical therapist assistant in patient management New inside the Third Edition Incorporation of the International Classification of Functioning Disability and Health disablement model Chapter on electronic documentation Screenshot examples of the popular WebPT electronic medical record platform Updated chapters on reimbursement and legal issues Additional examples for student practice included in each chapter Included with the text are online supplemental materials for faculty use in the classroom Documentation Basics for the Physical Therapist Assistant Third Edition is the perfect guide for all physical therapist assistant students and clinicians who want to update and refine their knowledge and skills in documentation

### **SOAP**

**Notes** Jeremiah Fleenor, 2007-03 A SOAP note records an encounter with a patient The components are Subjective what the patient tells the recorder Objective what the recorder observes Assessment recorder's summation Plan recorder's actions based on the assessment

### **Documentation for Physical Therapist Practice** Jacqueline A. Osborne, 2015-07-31

Documentation for Physical Therapist Practice A Clinical Decision Making Approach provides the framework for successful documentation It is synchronous with Medicare standards as well as the American Physical Therapy Association's recommendations for defensible documentation It identifies documentation basics which can be readily applied to a broad spectrum of documentation formats including paper based and electronic systems This key resource utilizes a practical clinical decision making approach and applies this framework to all aspects of documentation This text emphasizes how the common and standard language of the Guide to Physical Therapist Practice and the International Classification of Functioning Disability and Health ICF model can be integrated with a physical therapist's clinical reasoning process and a physical therapist assistant's skill set to produce successful documentation Includes content on documentation formations

Initial Evaluations Re examination Notes Daily Notes Conclusion of the Episode of Care Summaries Home Exercise Program Reviews all the important issues related to style types of documentation and utilization of documentation Covers documentation relevant in different settings inpatient home health skilled nursing facility outpatient Helps students learn how to report findings and demonstrate an appropriate interpretation of results Includes up to date information in line with APTA Guidelines for Defensible Documentation World Health Organization International Classification of Functioning Disability and Health Mode and Medicare Reviews electronic documentation ICD 9 ICD 10 and CPT codes Includes important chapters on Interprofessional Communication Legal Aspects Principles of Measurement      **Starting Your Practice** Jean Nagelkerk, 2005-10-28 This unique resource is an ideal career planning guide for advanced practice students recent graduates and practicing nurse practitioners who want to expand their careers It s filled with helpful guidelines and proven strategies for success in every aspect of NP practice including certification and licensure finding and negotiating a practice opportunity and developing community and professional partnerships Guidelines for completing the necessary requirements for certification and licensure Tips for finding and negotiating a practice opportunity Strategies for using available technology and tools such as the internet and PDAs to create a successful clinical practice environment Ideas for developing a community partnership by creating successful professional and clinical contacts in the community Practical advice on how best to market oneself and interview with potential employers Key information on establishing systems in practice using tools to enhance clinical judgment and other important responsibilities related to clinical practice A wealth of real world examples including resumes collaborative agreements contracts business plans billing and coding and productivity flowcharts provide essential resources for a successful practice      **Athletic Training Clinical Workbook** Kim Miller-Isaac, Melissa Noble, 2014-07-17 A one of a kind workbook for certification exam success Waiting in the training room Have downtime on the field Take this portable workbook with you wherever you go to confidently prepare for the competencies required by the BOC and meet the challenges you ll face in clinical and practice      Patient-Centered Care for Pharmacists Kimberly A. Galt, 2012-02-20 Patient centered care is at the heart of today s pharmacy practice and ASHP s Patient Centered Care for Pharmacists gets to the heart of the subject Formerly Developing Clinical Practice Skills for Pharmacists this revised resource has been redeveloped to compliment the changing emphasis in pharmacy practice to patient centered care and the contemporary context of healthcare delivery To understand and treat the whole person and learn to use a realistic approach to time and resources students must connect their drug science knowledge to actual practice Useful in multiple courses in multiple levels Patient Centered Care for Pharmacists is a valuable resource that gives students and teachers alike more for their money In P1 P2 and P3 courses in areas from clinical skills to communications students can follow realistic case studies through typical processes to witness patient centered care in action Strong well developed case studies provide insight into today s vital topics Cultural differences among patients Documentation and health records Patient care plan development

Effective patient communication And much more **Canadian Clinical Nursing Skills and Techniques E-Book** Shelley Cobbett, Anne G. Perry, Patricia A. Potter, Wendy R. Ostendorf, 2019-05-21 NEW Fully revised for a Canadian classroom includes Canadian statistics references and resources protocols documentation standards delegation rules Canadian nursing best practice guidelines metric measurements and more NEW All topics skills and sample documentation conform to Canadian provincial and territorial scopes of practice and Canadian standards in nursing practice NEW Inclusion of Canadian concepts Person Centred Care Evidence Informed Practice Interprofessional Collaboration and Delegation and Care in the Community NEW Greater emphasis on cultural assessment considerations and caring for Indigenous and vulnerable populations NEW Thoroughly revised chapters reflect Canadian practice and guidelines including Emergency Preparedness and Disaster Management Palliative Care Cardiac Care Vascular Access and Infusion Therapy Oral Nutrition and Prevention of Skin Breakdown and Wound Care NEW Enhanced and updated art program includes 70 new figures Essentials for Nursing Practice - E-Book Patricia A. Potter, Anne G. Perry, Patricia A. Stockert, Amy Hall, 2018-03-12 Get a solid foundation in essential nursing principles concepts and skills Essentials for Nursing Practice 9th Edition combines everything you need from your fundamentals course and streamlines it into a format that's perfect for busy nursing students The ninth edition retains many classic features including chapter case studies procedural guidelines and special considerations for various age groups along with new content including a chapter on Complementary and Alternative Therapies interactive clinical case studies on Evolve a new Reflective Learning section and QSEN activities to encourage active learning Thoroughly reviewed by nursing clinical experts and educators this new edition ensures you learn nursing Essentials with the most accurate up to date and easy to understand book on the market Progressive case studies are introduced at the beginning of the chapter and are then used to tie together the care plan concept map and clinical decision making exercises Focused Patient Assessment tables include actual questions to help you learn how to effectively phrase questions to patients as well as target physical assessment techniques Nursing skills at the end of each chapter feature full bleed coloring on the edge of the page to make them easy to locate Safety guidelines for nursing skills sections precede each skills section to help you focus on safe and effective skills performance Detailed care plans in the text and on Evolve demonstrate the application of the 5 step nursing process to individual patient problems to help you understand how a plan is developed and how to evaluate care Unexpected outcomes and related interventions for skills alert you to possible problems and appropriate nursing action Patient Teaching boxes help you plan effective teaching by first identifying an outcome then developing strategies on how to teach and finally implementing measures to evaluate learning Care of the Older Adult boxes highlight key aspects of nursing assessment and care for this growing population Key points neatly summarize the most important content for each chapter to help you review and evaluate learning Evidence Based Practice boxes include a PICO question summary of the results of a research study and a F description of how the study has affected nursing practice in every chapter Patient Centered Care boxes address racial

and ethnic diversity along with the cultural differences that impact socioeconomic status values geography and religion 65  
Skills and procedural guidelines provide clear step by step instructions for providing safe nursing care 5 step nursing process  
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