

S.O.A.P. NOTE DOCUMENTATION

The SOAP Note method of patient information documentation is designed to be a systematic approach to documentation of pertinent medical information. A description of each component of the SOAP Note and several examples of SOAP Notes are noted below. Our use of the SOAP Note differs slightly from a true SOAP Note as used in the hospital environment.

- S:** The **S** of **SOAP** stands for **SUBJECTIVE**. In this section you will provide a brief statement as provided by the patient or bystander or a brief incident statement. This is typically a one line comment.
- O:** The **O** of **SOAP** stands for **OBJECTIVE**. In this section you will provide information about the patient or incident obtained through a variety of methods - physical exam, patient questioning, on scene observations.... In this area you will document vital signs, complaints, medications, allergies, physician names, signs & symptoms and all assessment findings.
- A:** The **A** of **SOAP** stands for **ASSESSMENT**. In this section you will give a brief statement regarding the suspected problem / diagnosis. This is not a "definitive" diagnosis as we are not physicians. This statement should generally be preceded by the terms "possible", "rule out" or "suspected".
- P:** The **P** of **SOAP** stands for **PLAN**. In this section we will list chronologically all treatment provided for the patient. This includes assessment, consultation / hospital contact, transport and receiving facility and patient priority.

SAMPLE CASE 1:

You have a 49 yr old, 200 lbs white male patient complaining of chest pains which he describes as sharp stabbing pains on the left side of his chest with radiation to the left arm. The pain began 1 hr ago and has intensified since its onset. He had a heart attack 2 yrs ago. He takes the following medications: NTG, Inderal, Isordil & Cardilate. He is allergic to Darvon. VS's = 150/88, HR 100, RR 22. He is alert and oriented and communicating appropriately. He is pale, warm and dry. His lungs are clear to auscultation bilaterally. He took 2 NTG's prior to the arrival of the ambulance. The discomfort began while he was moving heavy boxes. He denies SOB, dizziness, nausea or other obvious cardiovascular S&S's. His private physician is Dr. Jerome Hantman, a cardiologist at Howard County General Hospital. You will be transporting to your local hospital. Your treatment is as expected for a patient with the above mentioned S&S's.

- S:** "I've had this chest pain for about an hour".
- O:** 49 yr 200 lbs w/m in moderate distress c/o left sided chest discomfort described as "sharp stabbing pains with radiation to the left arm". The discomfort began approximately 1 hr before the ambulance arrived. His activity at the time was moving heavy boxes. He is A&O X 3. He is pale, W&D. Lungs - clear bilaterally. He denies SOB, dizziness, N&V and other cardiovascular complaints.

History: M.I. 2 yrs ago and angina. His attending physician is Dr. Hantman at HCGH. VS's = 150/88, HR 100 & regular, RR of 22 at 20:15 hrs. The vitals remained essentially unchanged. He took 2 NTG prior to the ambulance arrival with minimal relief. His other meds include: Inderal, Isordil and Cardilate (meds accompany patient). Allergies: Darvon. The discomfort being experienced at this time is not like that experienced during the M.I. of 2 yrs ago but more closely resembles the anginal pains experienced at times over the last 2 yrs. Previous anginal pains have been relieved with 1 or 2 NTG's. On a 1 - 10 rating system he rates his discomfort at a 5 or 6.

A: Chest discomfort of unknown etiology.

- P:
1. Assessment & crisis intervention.
 2. ALS requested.
 3. O2 15 lpm NRM.
 4. Recurrent assessment.
 5. Placed pt. in a semi-fowlers position for comfort.
 6. Contact with _____, the consulting hospital.
 7. NTG 0.4 mgs at 20:25 hrs with complete relief.
 8. Transport Priority 2 to _____ non-emergency.

Signed _____, EMT-B

SAMPLE CASE 2:

Your patient is a 20-25 yr old trauma victim as a result of a MVA. He is the vehicle driver and was not belted upon your arrival. He was seated behind the severely bent steering column when you approached the vehicle. He is unconscious and unresponsive to all forms of stimulation. Your examination reveals the following: a small contusion and laceration above the forehead into the scalp & an angulated fracture of the L lower arm. PERL. Hx and Meds ?? VS's at 23:15 hrs = 224/112, 50 and a RR of 44. You also observed that the windshield is shattered in front of the steering wheel. The physical exam is otherwise unremarkable.

S: Unconscious trauma victim.

O: 20-25 yr w/m approximately 180 lbs involved in a MVA. Vehicular damage severe involving the front of auto and drivers side. Single vehicle accident - auto into tree. The patient was seated behind the steering wheel and was unbelted upon the arrival of the ambulance. Unconscious and unresponsive to deep painful stimulation. PERL. Small laceration and contusion noted near the scalp line above the forehead. The left lower arm is angulated near the wrist. Distal pulse and capillary refill normal in all extremities. Lungs clear. VS's 23:15 hrs = 224/112, HR 50 & 44 deep breaths per minute. Physical exam otherwise unremarkable. Hx, Meds, Allergies???

A: Possible multi-system trauma – suspect closed head injury.

P: 1. Assessment and request for ALS.

2. Spinal immobilization.
3. O2 NRM 15 lpm then BVM 20 bpm.
4. Rapid extrication from auto.
5. Slight elevation of head of backboard.
6. Transport by Helicopter to _____ Priority 1.

Signed....., EMT-B

SAMPLE CASE 3:

22 yr black female who allegedly ingested an undetermined number of Lomotil tablets. Time of ingestion is not known. You arrive to find her unable to converse normally, mumbling incomprehensibly when painful stimulation is introduced. Pupils - constricted. VS's = 100/72, HR 66 & RR 8-10 and shallow. Hx, allergies and routine meds are not known. She was found by a roommate. No evidence of trauma. Recently depressed.

S: Unconscious person - possible O.D.

O: 22 yr B/F approximately 110 lbs possibly ingested an undetermined amount of Lomotil. Recently depressed according to her roommate. Responsive to deep pain only - mumbles incomprehensibly. VS's = 100/72, HR 66 & RR 8-10 shallow breaths per minute. Pupils constricted. Hx, meds & allergies are unknown. Secondary exam reveals no evidence of trauma. Breath sounds ? due to shallow effort.

A: Possible Lomotil overdose?

- P:
1. Assessment.
 2. Assist ventilations - rate 12 to 16 breaths per minute.
 3. Oropharyngeal airway.
 4. Paramedic Unit requested to assist – Paramedic 5-5.
 5. Paramedic transport Priority 1 emergency to _____.

Signed....., EMT-B

SAMPLE CASE 4:

MVA. Patient refusing services. Minor vehicular damage R front bumper. Driver advising he was belted and uninjured. 56 yr b/m. Agreed to vitals - 122/84, 78, 22. A & O X 3. Ambulating before arrival of ambulance.

S: Minor MVA.

O: Minor MVA. Minimal front end damage to a passenger vehicle. Driver of vehicle states that he was belted at the time of the accident. Low speed impact into guard rail. Refusing services. 56 yr B/M. No c/o injury or pain. Denies loss of consciousness. Alert & oriented. VSS: 122/84, 78 & 22. Walking around accident scene upon arrival of ambulance. No evidence of trauma.

A: Minor MVA - patient refusing services.

- P:
1. Assessment.
 2. Conversation with vehicle occupant - denies injury - refusing transport.
 3. Encouraged patient to seek medical attention if any signs or symptoms of injury should occur. Offered ambulance transport. Refused.
 4. Reviewed sign-off information and obtained signature. HCPD witness.
- Signed....., EMT-B

keb 12/2004