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Wondering how to write SOAP notes? The SOAP format can be one of the most effective ways for clinicians to document and objectively assess, diagnose, and track plans for clients. The SOAP note format (Subjective, Objective, Assessment, and Plan) is a way for clinicians to document, assess, diagnose, and track plans for clients.The Subjective section includes what the client says about their symptoms and medical history, while the Objective section includes the physical findings from the session, such as vital signs and the client's observed appearance.The Assessment section is where the clinician uses the insights from the Subjective and Objective sections to interpret the situation and provide a diagnosis, if applicable.The Plan section outlines the treatment plan for the client, short- and long-term goals, and expectations for future sessions.Best practices include prompt documentation, clear language, and adherence to HIPAA guidelines while avoiding subjective opinions and irrelevant details.Knowing how to write SOAP notes is incredibly useful. The SOAP template helps clinicians capture the information needed for clear, efficient, and effective record keeping. In the SOAP format, SOAP stands for Subjective, Objective, Assessment, and Plan. Each letter refers to one of four sections in the document you will create with your notes. In this article, we'll cover how to write SOAP notes, describing the SOAP format and what to include in each section. We've also compiled some SOAP note examples to help you get started in keeping session notes and streamlining your note-taking process.What's a SOAP note?According to the journal Academic Medicine, the SOAP format was developed in the 1950s by Lawrence Weed, a professor of medicine and pharmacology at Yale University. Originally referred to as a problem-oriented medical record (POMR), the SOAP note evolved, and today it's widely used by practitioners across many healthcare disciplines—including mental health professionals—to document and organize findings in an objective way. Though the specific information and length of these documents varies by discipline, it's important to learn how to write SOAP notes because they all follow the same basic structure. This standardization is easily recognizable by providers in other specialities—making it easy to coordinate care for your clients if needed.How to write a SOAP noteLearning how to write SOAP notes is generally a straightforward process because it always follows a specific and precise structure. However, it does take some practice. SOAP notes include four headings that correspond with each letter of the acronym: SubjectiveObjectiveAssessmentPlan The notes and records you enter under each heading will depend on your clinical specialty, who your client is, and what you're working on during your sessions together. We've broken down the order of how to write SOAP notes and provided suggestions for what to include in each section as recommended by a review of peer-reviewed articles in StatPearls.This section is for subjective reporting of how your client says they are feeling during the session and what they report about their current symptoms. It can also contain information gathered from family members and reviews of past medical records.Many mental health practitioners focus on what's known as a "Chief Complaint"(CC) or the presenting problem in this section. Even if the client reports multiple CCs, it's important to try to identify the most compelling problem so that you can ultimately provide an effective diagnosis. Some general areas of inquiry as you try to identify the primary CC may include: history of present illness, medical history, review of systems, and current medications.Here are some questions to ask to help uncover your client's Chief Complaint:Describe your symptoms in detail. When did they start and how long have they been going on?What is the severity of your symptoms and what makes them better or worse?What is your medical and mental health history?What other health-related issues are you experiencing?What medications are you taking?Make sure any opinions or observations you include in the section are attributed to who said them—whether it's yourself or your client. Because this is a subjective section, you don't want to pass off any of this information as fact.ObjectiveThe SOAP notes objective section should be made up of physical findings gathered from the session with your client. Some examples of SOAP charting for this section include:Vital signsRelevant medical records or information from from other specialistsThe client's appearance, behavior, and mood in sessionNote: This section should consist of factual information that you observe and not include anything the patient has told you.AssessmentThe assessment section combines all the information gathered from the subjective and objective sections. It's where you describe what you think is going on with the patient. You can include your impressions and your interpretation of all of the above information, and also draw from any clinical professional knowledge or DSM-5 criteria/therapeutic models to arrive at a diagnosis (or list of possible diagnoses).PlanThe last section of your SOAP note should outline your plan for next steps to treat the patient, including short- and long-term goals for your patient. Be specific about what you plan to work on in the next session or in general and your expectations for the duration of treatment.Therapy SOAP note exampleIf you're looking for an example for writing SOAP notes, here's a SOAP format example that may help behavioral health practitioners better understand how to do a SOAP note.SubjectiveClient reports feeling more anxious this week. She said she felt more jittery and on-edge, and reports having more anxious thoughts that were harder to control. ObjectiveDuring the session, the client was fidgety, wringing her hands, and speaking quickly. She appeared to have difficulty concentrating and asked me to repeat questions multiple times before responding. Client described a fear of losing her job and her housing, though admitted she didn't have any evidence those events were imminent. AssessmentBased on the client's reports and in-session observations, the client's anxiety has increased but continues to meet criteria for generalized anxiety disorder (GAD). Plan Recommended that client see a primary care physician to rule out any thyroid or other medical condition. Client will continue coming to therapy once a week for the foreseeable future to treat anxiety through cognitive behavioral therapy (CBT). Also recommended that the client try meditation and other mindfulness techniques at home in between sessions. SOAP note example for speech-language pathologists (SLPs)Speech-language pathologists (SLPs) also need to know how to write SOAP notes, as SLPs use the SOAP format to capture clinical information about client visits, current assessments, and outcomes. Here's sample SOAP charting copy an SLP might use for a SOAP note:Subjective The client reports increased vocal demands since the last meeting due to additional meetings at work. She notes her colleagues commented "Your voice is back!" after her last work presentation, but that she still experiences intermittent vocal fatigue during social events. She reports she has been incorporating her semi occluded vocal tract straw (SOVT) routine three times a day for five minutes. Objective Led the client through SOVT exercises with a straw in water. Client independently achieved optimal voicing in 5/5 opportunities. Introduced conversational training therapy (CTT) where client differentiated between her "husky" voice and her "presenter" voice in 5/5 opportunities. Practiced functional phrases where client achieved "presenter" voice in 8/10 opportunities with moderate visual cues. The client's vocal effort using CTT was 4/10. Assessment The client met goals of optimal voicing to meet vocational demands, as evidenced by an improvement from vocal effort of 7/10 ("somewhat hard") to 4/10 ("somewhat easy"). She is pressing toward carryover of SOVT strategies to meet social demands.PlanContinue the current plan of care. Target optimal voicing in functional environments with CTT techniques. Introduce additional compensatory strategies to manage vocal load across vocational and social settings. How to use SOAP notes with your practice management systemSimplePractice is the HIPAA-compliant practice management software with easy and secure therapy notes, progress notes, SOAP notes, and other note-taking templates built into the platform. This makes it fast and simple to access your notes and fill them out after each session. With built in templates for SOAP notes in the SimplePractice software, you'll never find yourself searching for instructions for how to write SOAP notes ever again. SimplePractice makes it easy for you to get more organized and run a fully paperless practice.If your EHR doesn't have built-in SOAP notes, you can download our free SOAP note template to keep on hand, or make your own following the guidelines we provided above. Remember, SOAP notes are meant to document your findings in a way that's easy to record and refer back to. Consequently, you should use the format that makes the most sense for your practice.If you've been considering switching to a fully integrated, HIPAA-compliant practice management software, SimplePractice gives you everything you need to streamline your note-taking process. You can pull a SOAP note template from our robust template library, use our "load previous note" feature to easily update your notes each session, and send follow-up information about your sessions to your clients through the client portal. Used by over 225,000 clinicians nationwide, SimplePractice is consistently rated as the very best practice management software for therapists, speech-language pathologists, occupational therapists, and other practitioners in the health and wellness industry.To try SimplePractice out, sign up for a free, 30-day trial. No credit card needed. SourcesHow SimplePractice streamlines running your practiceSimplePractice is HIPAA-compliant practice management software with everything you need to run your practice built into the platform—from booking and scheduling to insurance and client billing.If you've been considering switching to an EHR system, SimplePractice empowers you to streamline appointment bookings, reminders, and rescheduling and simplify the billing and coding process—so you get more time for the things that matter most to you.Try SimplePractice free for 30 days. No credit card required. Begin your SOAP note by documenting the information you collect directly from your patient; avoid injecting your own assessments and interpretations. Include the following: 1. The patient's chief complaint. This is what brought the patient to the hospital or clinic, in their own words. 2. The history of the patient's present illness, as reported by the patient. To standardize your reporting across notes, include information using the acronym OPQRST: The onset of the patient's symptoms. Any palliating or provoking factors. The quality of the patient's symptoms. The region of the body affected and (if the symptom is pain) if there is any radiation. The severity of the patient's symptoms and whether or not there are any other associated symptoms. The time course of the patient's symptoms. 3. Pertinent medical history, including the patient's: Past medical and surgical history. Family history. Social history. 4. A current list of the patient's medications, including the doses and frequency of administration. Objective The objective section of your SOAP note should, unsurprisingly, comprise objective information you collect from the patient encounter. 1. Start with the patient's vital signs. Be sure to record the patient's temperature, heart rate, blood pressure, respiratory rate and oxygen saturation. 2. Transition to your physical exam. Begin with a general impression of the patient, followed by the results of your head, ears, eyes, nose and throat; respiratory; cardiac; abdominal; extremity; and neurological exams. Additionally, include the results of any other relevant exams you've performed. 3. Report the results of any other diagnostics that have been performed, such as: Laboratory tests, including basic metabolic panels, complete blood counts and liver function tests. Imaging, including X-rays, computed tomography scans and ultrasounds. Any other relevant diagnostic information, including electrocardiograms. Assessment After you've completed the subjective and objective sections of your note, report your assessment. 1. Craft a one- to two-sentence summary that includes the patient's age, relevant medical history, major diagnosis and clinical stability. For example: "Ms. K is an 85-year-old woman with a past medical history of multiple urinary tract infections who presented to the emergency room with dysuria, fatigue and a fever secondary to a new urinary tract infection. She is now clinically stable and has transitioned from intravenous to oral antibiotics." If the patient has multiple major diagnoses, these should all be mentioned in your summary statement. 2. If your patient is experiencing any new symptoms, be sure to include a differential diagnosis as well. Aim to include at least two or three possible diagnoses. Plan Complete your SOAP note with your plan. 1. Create a list of all of the patient's medical problems. Your problem list should be ordered by acuity. 2. Propose a plan to manage each problem you've identified. For example, if you're in the midst of treating a bacterial infection, indicate that you plan to continue antibiotics. 3. If you're taking care of an inpatient, be sure also to note their deep vein thrombosis prophylaxis, code status and disposition. As with any skill, practice makes perfect. Try to view SOAP notes as learning opportunities, and with enough effort and time, you'll become proficient in drafting these vital medical communications. Explore solutions for practicing clinicians, residents, students, and faculty from Lippincott Medicine and deliver better patient outcomes. The Subjective, Objective, Assessment and Plan (SOAP) note is an acronym representing a widely used method of documentation for healthcare providers. The SOAP note is a way for healthcare workers to document in a structured and organized way.[1][2][3]This widely adopted structural SOAP note was theorized by Larry Weed almost 50 years ago. It reminds clinicians of specific tasks while providing a framework for evaluating information. It also provides a cognitive framework for clinical reasoning. The SOAP note helps guide healthcare workers use their clinical reasoning to assess, diagnose, and treat a patient based on the information provided by them. SOAP notes are an essential piece of information about the health status of the patient as well as a communication document between health professionals. The structure of documentation is a checklist that serves as a cognitive aid and a potential index to retrieve information for learning from the record.[4][5][6] Structure The 4 headings of a SOAP note are Subjective, Objective, Assessment and Plan. Each heading is described below. Subjective This is the first heading of the SOAP note. Documentation under this heading comes from the "subjective" experiences, personal views or feelings of a patient or someone close to them. In the inpatient setting, interim information is included here. This section provides context for the Assessment and Plan. Chief Complaint (CC) The CC or presenting problem is reported by the patient. This can be a symptom, condition, previous diagnosis or another short statement that describes why the patient is presenting today. The CC is similar to the title of a paper, allowing the reader to get a sense of what the rest of the document will entail.Examples: chest pain, decreased appetite, shortness of breath.However, a patient may have multiple CC's, and their first complaint may not be the most significant one. Thus, physicians should encourage patients to state all of their problems, while paying attention to detail to discover the most compelling problem. Identifying the main problem must occur to perform effective and efficient diagnosis. History of Present Illness (HPI) The HPI begins with a simple one line opening statement including the patient's age, sex and reason for the visit.Example: 47-year old female presenting with abdominal pain.This is the section where the patient can elaborate on their chief complaint. An acronym often used to organize the HPI is termed "OLDCARTS":Onset: When did the CC begin?Location: Where is the CC located?Duration: How long has the CC been going on for?Characterization: How does the patient describe the CC?Alleviating and Aggravating factors: What makes the CC better? Worse?Radiation: Does the CC move or stay in one location?Temporal factor: Is the CC worse (or better) at a certain time of the day?Severity: Using a scale of 1 to 10, 1 being the least, 10 being the worst, how does the patient rate the CC?It is important for clinicians to focus on the quality and clarity of their patient's notes, rather than include excessive detail. History Medical history: Pertinent current or past medical conditionsSurgical history: Try to include the year of the surgery and surgeon if possible.Family history: Include pertinent family history. Avoid documenting the medical history of every person in the patient's family.Social History: An acronym that may be used here is HEADSS which stands for Home and Environment; Education, Employment, Eating; Activities; Drugs; Sexuality; and Suicide/Depression. Review of Systems (ROS) This is a system based list of questions that help uncover symptoms not otherwise mentioned by the patient.General: Weight loss, decreased appetiteGastrointestinal: Abdominal pain, hematocheziaMusculoskeletal: Toe pain, decreased right shoulder range of motion Current Medications, Allergies Current medications and allergies may be listed under the Subjective or Objective sections. However, it is important that with any medication documented, to include the medication name, dose, route, and how often. Example: Motrin 600 mg orally every 4 to 6 hours for 5 days Objective This section documents the objective data from the patient encounter. This includes:Vital signsPhysical exam findingsLaboratory dataImaging resultsOther diagnostic dataRecognition and review of the documentation of other clinicians.A common mistake is distinguishing between symptoms and signs. Symptoms are the patient's subjective description and should be documented under the subjective heading, while a sign is an objective finding related to the associated symptom reported by the patient. An example of this is a patient stating he has "stomach pain," which is a symptom, documented under the subjective heading. Versus "abdominal tenderness to palpation," an objective sign documented under the objective heading. Assessment This section documents the synthesis of "subjective" and "objective" evidence to arrive at a diagnosis. This is the assessment of the patient's status through analysis of the problem, possible interaction of the problems, and changes in the status of the problems. Elements include the following. Problem List the problem list in order of importance. A problem is often known as a diagnosis. Differential Diagnosis This is a list of the different possible diagnosis, from most to least likely, and the thought process behind this list. This is where the decision-making process is explained in depth. Included should be the possibility of other diagnoses that may harm the patient, but are less likely.Example: Problem 1, Differential Diagnoses, Discussion, Plan for problem 1 (described in the plan below). Repeat for additional problems Plan This section details the need for additional testing and consultation with other clinicians to address the patient's illnesses. It also addresses any additional steps being taken to treat the patient. This section helps future physicians understand what needs to be done next. For each problem:State which testing is needed and the rationale for choosing each test to resolve diagnostic ambiguities; ideally what the next step would be if positive or negativeTherapy needed (medications)Specialist referral(s) or consultsPatient education, counselingA comprehensive SOAP note has to take into account all subjective and objective information, and accurately assess it to create the patient-specific assessment and plan.The order in which a medical note is written has been a topic of discussion. While a SOAP note follows the order Subjective, Objective, Assessment, and Plan, it is possible, and often beneficial, to rearrange the order. For instance, rearranging the order to form APSO (Assessment, Plan, Subjective, Objective) provides the information most relevant to ongoing care at the beginning of the note, where it can be found quickly, shortening the time required for the clinician to find a colleague's assessment and plan. One study found that the APSO order was better than the typical SOAP note order in terms of speed, task success (accuracy), and usability for physician users acquiring information needed for a typical chronic disease visit in primary care. Re-ordering into the APSO note is only an effort to streamline communication, not eliminate the vital relationship of S to O to A to P.A weakness of the SOAP note is the inability to document changes over time. In many clinical situations, evidence changes over time, requiring providers to reconsider diagnoses and treatments. An important gap in the SOAP model is that it does not explicitly integrate time into its cognitive framework. Extensions to the SOAP model to include this gap are acronyms such as SOAPE, with the letter E as an explicit reminder to assess how well the plan has worked.[7][8][9][10]Medical documentation now serves multiple needs and, as a result, medical notes have expanded in both length and breadth compared to fifty years ago. Medical notes have evolved into electronic documentation to accommodate these needs. However, an unintended consequence of electronic documentation is the ability to incorporate large volumes of data easily. These data-filled notes risk burdening a busy clinician if the data are not useful. As importantly, the patient may be harmed if the information is inaccurate. It is essential to make the most clinically relevant data in the medical record easier to find and more immediately available. The advantage of a SOAP note is to organize this information such that it is located in easy to find places. The more succinct yet thorough a SOAP note is, the easier it is for clinicians to follow.Review Questions1.Gogineni H, Aranda JP, Garavalia LS. Designing professional program instruction to align with students' cognitive processing. Curr Pharm Teach Learn. 2019 Feb;11(2):160-165. [PubMed: 30733012]2.Andrus MR, McDonough SLK, Kelley KW, Stamm PL, McCoy EK, Lisenby KM, Whitley HP, Slater N, Carroll DG, Hester EK, Helmer AM, Jackson CW, Byrd DC. Development and Validation of a Rubric to Evaluate Diabetes SOAP Note Writing in APPE. Am J Pharm Educ. 2018 Nov;82(9):6725. [PMC free article: PMC6291674] [PubMed: 30559501]3.Lisenby KM, Andrus MR, Jackson CW, Stevenson TL, Fan S, Gaillard P, Carroll DG. Ambulatory care preceptors' perceptions on SOAP note writing in advanced pharmacy practice experiences (APPEs). Curr Pharm Teach Learn. 2018 Dec;10(12):1574-1578. [PubMed: 30527822]4.Sando KR, Skoy E, Bradley C, Frenzel J, Kirwin J, Urteaga E. 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A quality improvement project using a problem based post take ward round proforma based on the SOAP acronym to improve documentation in acute surgical receiving. Ann Med Surg (Lond). 2016 Feb;5:45-8. [PMC free article: PMC4706565] [PubMed: 26858834]10.Seo JH, Kong HH, Im SJ, Roh H, Kim DK, Bae HO, Oh YR. A pilot study on the evaluation of medical student documentation: assessment of SOAP notes. Korean J Med Educ. 2016 Jun;28(2):237-41. [PMC free article: PMC4951742] [PubMed: 26996436] Disclosure: Vivek Podder declares no relevant financial relationships with ineligible companies. Disclosure: Valerie Lew declares no relevant financial relationships with ineligible companies. Disclosure: Sassan Ghassemzadeh declares no relevant financial relationships with ineligible companies. How do doctors organize all the information about their patients? Back in the 1950s, Lawrence Weed asked himself the same question and came up with a solution — the SOAP notes. SOAP notes are a way for healthcare providers to document patient data more efficiently and consistently. Today, the C-CDA (Consolidated Clinical Document Architecture) has set out a standard format for SOAP notes with a wide range of sections. However, not all sections are needed for every note, so healthcare providers can choose the most relevant sections for their specialty. This article provides examples of SOAP notes in both narrative and abbreviated formats, as well as a list of acceptable clinical documentation abbreviations. NOTE: Abbreviations can improve efficiency but can be confusing if used incorrectly. The Joint Commission's "Do Not Use" list and the Institute for Safe Medication Practices' list of Error-Prone abbreviations are essential to maintaining clear and safe medical documentation. Long SOAP Note Example Subjective Chief Complaint The patient states they have been "stressed out by daily life" and has had difficulty concentrating for over three months. Medical HistoryThe problem began around three months ago and has continued consistently, affecting the patient's mental and cognitive functioning. Daily stressors primarily exacerbate the stress and concentration problems and seem to improve slightly with rest and relaxation. The patient notes that the intensity of the symptoms fluctuates throughout the day, often worsening during periods of high stress. They rate the severity of their symptoms as 7 out of 10, indicating a significant impact on their daily functioning. Objective The patient appeared mildly anxious during the session, but no acute physical abnormalities were observed. A cognitive assessment revealed moderate impairment in concentration and attention, consistent with the patient's complaints. Assessment The patient has moderate anxiety and difficulty concentrating due to chronic stress and a family history of anxiety and depression. Plan The patient will continue their current medication regimen and begin CBT. Follow-up appointments are scheduled, and referrals for stress management programs are made. The patient is also advised to engage in regular physical activity and mindfulness practices. Short SOAP Note Example Subjective CC Pt. Is "stressed out by daily life" and has difficulty concentrating for over 3 mo. MH Prob started 3 mo. ago, consistently affecting pt's mental function, w/ sx worsening under stress and Sl. improving w/ rest. Pt rates severity as 7 out of 10. ObjectiveDuring the session, pt. was mildly anxious, but 0 acute physical abnormalities observed. Cognitive assessment → mod impairment in concentration and attention, consistent w/ pt's complaints. Assessment Pt. mod anxiety and difficulty concentrating b/c of chronic stress and FH of anxiety and depression. PlanPt. cont current med regiment and begin CBT. F/U appt is scheduled and ref for stress management program. Pt. is advised to engage in reg. physical activity and mindfulness practice. SOAP Notes Structure The SOAP notes structure organizes scattered patient data into a clear and cohesive health narrative. Recognizing the need for a structured but comprehensive approach to capturing health stories, an alliance of healthcare vendors, providers, and associations spearheaded an initiative to standardize medical documentation called The Health Story Project. Although it's no longer active, its impact on the health IT community has been significant. For example, it has seen extensive application in educating professionals on creating thorough electronic health records, setting the stage for today's advanced documentation practices. The following sections highlight the basic information consistent with the SOAP Notes framework, as detailed in the HL7 CDA R2 Implementation Guide. We encourage you to regularly review the updated versions of this guide to get a more complete understanding and stay up to date. SOAP notes are made up of four major sections: Subjective The Subjective section provides a narration-style description of the patient's current condition. It encompasses the patient's experiences, views, and feelings, offering a crucial context for the Assessment and Plan sections. These patient-oriented data have to address specific key components, including but not limited to: Reason for Visit and/or Chief Complaint Depending on local policy, providers can submit these components separately or combined. The "Reason for Visit" reflects the doctor's perspective on why the patient seeks care, while the "Chief Complaint" summarizes the patient's account of their symptoms. History of Present Illness Physicians provide more details on the patient's complaints in this sub-section, emphasizing the historical context. To ensure a complete outline, use the OLDCARTS acronym: Onset – When did the problem begin? Location – Where is it occurring? Duration – How long has the problem lasted? Characterization – How does the patient describe the problem? Alleviating/Aggravating factors – What factors make it better/worse? Radiation – Does it remain in one place or spread to other areas? Temporal factors – Does the problem vary in intensity throughout the day? Severity – On a scale from 1 (mild) to 10 (severe), how would the patient rate the intensity of their symptom? Social History Section This section covers social and demographic information that could affect the patient's physical, mental, or emotional well-being, such as smoking, pregnancy, employment, marital status, race, ethnicity, and religious affiliation. Objective The Objective section of the SOAP notes includes patient data collected through tests, measurements, and observations that provide quantifiable or categorizable results. This section can also include information specific to Procedure and Operative Notes and Inpatient Encounter Notes. Typically, the Objective section comprises the following components: Objective Section This subsection includes significant positive and negative test results, such as data from physical examination findings, a comprehensive review of body systems, and other relevant observations and measurements. Problems Section This section lists all relevant clinical problems, including current and historical issues, to reflect the patient's overall health status. Medication Section This is where clinicians document the patient's current medication regimen and relevant medication history. It can also detail the patient's prescription and dispensing history here to get a comprehensive overview. Recording is essential for tracking and managing treatment. It allows for reviewing past prescriptions, making adjustments based on the patient's condition, and planning future steps. Proper recording helps monitor progress and make informed adjustments. Results Section The Results section presents the outcomes of observations generated by imaging, laboratories, and other procedures. This is where healthcare providers record notable findings, such as significant trends or abnormal values, which can help them fill in the Assessment and, ultimately, the Plan sections. Assessment The Assessment section, also known as "impression" or "diagnoses" outside of CDA, is a crucial component of the SOAP notes. It contains the clinician's conclusions and treatment guidance, combining Subjective and Objective data. Doctors can also write Procedural and Operative notes, as well as Inpatient Encounter Notes here. This section includes some of the following components: Assessment In this subsection, sometimes called "Assessment and Plan," clinicians outline the conclusions and assumptions guiding the patient's treatment. Submitting the Assessment and Plan together or separately is possible depending on local policy requirements. Postprocedure Diagnosis When healthcare professionals make or confirm a diagnosis during medical procedures, they record it here. This information gives valuable insights into outcomes and helps guide future care decisions. Clinicians use the Assessment information to create the Plan, the final part of the SOAP notes. Plan The Plan outlines the patient's goals and desired care outcomes and guides clinicians on the steps to follow during patient management. This section also incorporates elements specific to Procedure and Operative Notes and Inpatient Encounter Notes. Key components of the Plan section include: Advance Directives Section This subsection contains vital information about the patient's healthcare preferences and legal arrangements, including healthcare proxies, living wills, CPR status, etc. Plan of Treatment Formerly known as the "Plan of Care," this subsection outlines pending orders, interventions, encounters, services, and procedures for the patient. It focuses exclusively on future, unfulfilled, or incomplete requests, covering all active, pending events of clinical significance to the patient's care. The Plan section ensures continuity and consistency in treatment approaches by providing a clear roadmap for patient care. In addition to the fundamental SOAP notes components, the SOAP Notes can include other data. Other Info SOAP notes can include additional sections that are not part of the main structure. These are: Encounters Section This section provides a detailed account of healthcare encounters relevant to the patient's current or past health status. Documenting these interactions can help clinicians gain valuable context about the patient's medical history and the continuity of care they've received. This information creates a clearer picture of the progression of conditions and the effectiveness of previous interventions. Payers Section The Payers section details the patient's financial arrangements for healthcare, including third-party insurance, self-pay options, and other guarantors. It also identifies who is responsible for the care costs, providing essential information for billing and administration. Physicians find all the contact and billing details for each payer here, as well as authorization details for referrals, therapies, procedures, or devices. While these sections may not directly affect clinical decision-making, they are significant in ensuring seamless care delivery and proper administrative processes. Recognizing that clinicians sometimes find writing SOAP notes challenging, we've prepared some recommendations to streamline the process. In addition to making the task easier, these tips will ensure that one's notes are more manageable, accurate, and efficient. Tips for Writing SOAP Notes The importance of SOAP notes in the patient-physician interaction cannot be overemphasized. Despite the potential to vary their style format, all SOAP notes must include Subjective, Objective, Assessment, and Plan sections. These notes facilitate communication, as they can convey relevant information to other healthcare professionals, insurance companies, and legal practitioners. We've compiled the following tips to help healthcare providers create clear and concise SOAP notes: Prioritize interaction and document later The goal here is to focus on the patient during the visit. Take brief personal notes and then write formal SOAP notes in a readable format afterward. This approach ensures undivided attention during interaction with the patient and a more comprehensive documentation. Avoid delaying the paperwork Document encounters immediately after the visit, ideally within 10 minutes, to ensure all necessary details are fresh in your mind. Prompt documentation reduces the risk of missing important information. Short narratives are your friends when it comes to note-writing. Be concise while writing and document only what is most important. This approach saves time and provides more valuable information to other practitioners involved in the treatment process. Avoid fragmented and unrelated sentences. Present all information clearly and concisely, as it will eventually be linked and referenced to related content within and between practices. Provide specific, evidence-based information without being judgmental or presumptuous. Avoid making statements without supporting evidence to maintain objectivity. Improve clarity by identifying subjects using terms like "the client" or "this clinician" to avoid ambiguity. This practice ensures clear attribution of actions and observations. Try to include paraphrased statements, relevant quotes, patient-reported progress, and connections to the goals previously stated in the Subjective section. Depending on your specialty, note the client's level of attention, engagement, feedback from family or other providers, and any client testimonials that are considered significant. While trying to get your SOAP notes in order, remember that the HIMSS Health Story Project states, "Clinical records must be complete, well-organized, easy to navigate, concise, logical, and adaptable to the needs of the user, shareable, readily available, and secure." The SOAP notes must accurately capture and reflect the clinician's thought process, providing a comprehensive yet concise record of patient care. Now, let's get to the most interesting part. Common Abbreviations To streamline the note-taking process, we've compiled an essential list of abbreviations for healthcare providers. Although this list isn't exhaustive, it's worth checking the "Do Not Use" list of abbreviations and the list of Error-Prone abbreviations from regulatory bodies. Additionally, most healthcare facilities have their own list of approved abbreviations, so it is crucial to stick to one's institution's guidelines to ensure clarity and patient safety in the documentation. Download medical abbreviations