S.OA.P. CHARTING

A method of documentation used by healthcare providers to describe events that took place during time spent with individuals either on the phone or in person.

Subjective Findings:
Subjective observations are symptoms the patient verbally expresses or as stated by a significant other. (Ex. "I feel hot")

- Chief complaint
- Patient perceptions
- Patient experiences
- Patient perspectives
- Occupational history
- Geographical history
- Smoking history
- Social history
- Recreational history
- Medical history
- Pain location, duration, radiation and intensity

Objective Findings:
Objective observations include symptoms that can actually be measured, seen, heard, touched, felt, or smelled. (Ex. Temperature of 40 C)

- Vital signs: HR, RR, BP, Temp.
- Physical Exam
- Chest X-ray
- ECG
- Heart sounds
- Hemodynamic measurements
- CBC
- ABGs
- SpO2
- Electrolytes

- Blood chemistries
- Enzymes
- Medications

Assessment:
Assessment is the diagnosis of the patient's condition. It is the health care provider's interpretation of the subjective and objective findings. (Ex. Patient is febrile)

- It is suggested that for any abnormal piece of data collected, an assessment should be written.

Plan:
The last part of the SOAP note is the healthcare provider's plans and / recommendations. (Ex. Medicate patient with Tylenol)

- For each assessment a plan or recommendation should be suggested.

References

RC Educational Consulting Services, Inc. (2010). S.O.A.P charting. Retrieved from http://www.rcecs.com/MyCE/PDFDocs/course/V7120.pdf

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