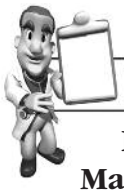
Name _____ Date _____



Health Informatics

Project 3.4 Topic: Chart in SOAP Format

Materials Needed

- Student Information Sheet
- Patient Medical Records from each of the five scenarios

Introduction

Read over the patient charts included with each of the scenarios in this program. Like the charts in the scenarios, every medical chart is done in the SOAP format, which stands for Subjective (S), Objective (O), Assessment (A) and Plan (P). The criteria for each section are listed below:

S (Subjective): This section is a record of patient-reported data, including what the patient says, height and weight if stated by the patient, appetite, complaints of pain.

O (Objective): Factual information that can be confirmed or verified is recorded in this section. Information includes diet prescribed, any current medications, actual height and weight, blood pressure, temperature, physical signs, laboratory values and results of a physical exam including extremities, thoracic/abdominal/genital, hearing, heart rate, etc.

A (Assessment): The health care professional records impressions in this section, including suspected diagnosis. Impressions are based on the objective observations, with consideration for patient-reported information.

P (Plan): This information includes any orders for laboratory tests, X-rays, physical therapy, diet, speech therapy, etc., and includes new or continued medications.

Procedure

Using the criteria above, create a SOAP chart for Jack Warner from the following information. The information was taken on September 16, 2008, at the rehabilitation hospital where Mr. Warner has been convalescing after a stroke. Your SOAP chart will accompany him to the assisted living facility where he hopes to move.

> Pt is 59 y.o. male named Jack Warner, who is post-acute CVA living on rehab floor, room 215A. Pt has a history of high cholesterol, atrial fibrillation and hypertension controlled with Lipitor and Hygroton. Patient has a BP of 136/92, a pulse of 86 that is irregular, respirations of 16, clear lungs. Abdomen is soft with no masses present. Patient is able to ambulate without assistance, using walker. Fully moves all extremities. Fine motor skills are still lacking. Patient is able to swallow. Will continue with soft diet. Speech/language pathology to assess swallowing and speech. Pt progressing well. Will consider discharging home once SLP feels pt is no longer at risk of aspiration. Retest labs: PTT, EKG, BUN. Continue with OT and PT.

(continued)

Name _____ Date _____

Project 3.4: *(continued)*

PATIENT MEDICAL RECORD

Patient Name: Jack Warner **Date of Admission:** 8/18/08

Address: 22 Maple Street

City/State/ZIP: Webster, WY 82065

DOB: 10/1/49

Sex: Male

Room: 215A

Doctor: Mary Beth Morrison, MD

S:

O:

A: .

P: