SOAP Notes â€“ the Report Card of a Patient

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Documenting encounters with patients in the medical record forms an integral part of working in most hospitals and health care units. This calls for the need of soap notes as this method of documentation enables the healthcare providers to write out notes in the patientâ€™s medical record conveniently and easily. This documentation format is basically an acronym for subjective, objective, continuous assessment and plan execution. These notes are used by doctors, health counselors and nurses and provide consistent documentation at all times. These can be easily reviewed by external auditors or accreditation councils for finding out their required information.

Using this form of documentation is quite easy and can be started by using the desired format adopted by the hospital or health care unit. Generally documentation is commenced by listing the patientâ€™s name, date of service, allotted case number and followed by diagnosis carried out or procedure coding. The remaining part of the note should be classified into four distinct sections. Here you can write the subjective part of the noted observations conducted on the patient. Generally all observations or remarks should be subjective in this section. The next section forms the objective part of the note where conclusions drawn from viewing the patient including patientâ€™s physical measurements like temperature of the body etc are addressed.

The next section of the note forms the assessment part which is basically the diagnosis report of the patient and his/her present status. Results of all diagnosis can be written down in the assessment section. The last part of the note incorporates the plan section which includes all prescribed medication and treatments administered to the patient along with their follow up care. These notes are extremely handy as it shows the daily progress in the recovery of a patient who has undergone a major operation.

Accurate and precise record keeping is advisable at all times especially if you are working in a hospital or as a health care professional. All parts of a SOAP note is basically a progress report of a patient which serves to understand the time of patientâ€™s full recovery for leading a normal life.

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