

## Tips for SOAP Writing

The VMTH physical exam sheet uses a check list system, but in practice, you will want to develop a systematic written format to make sure that you describe all relevant exam findings, even when they are normal.

During your 4<sup>th</sup> year, in order to develop your ability to generate differential lists, you should initially list out all problems and your top 3 rule-outs for each problem. As you gain experience with cases and SOAP writing, you will be able to group certain problems together for one list of differentials, but to start, list them out with their differentials. Then you can determine whether one differential could explain all of the important problems.

### SOAP format:

**S:** subjective findings – how does your patient generally look today (bright, alert, responsive, dull, depressed, etc., compared with yesterday if applicable)

**O:** all objective findings. Findings are simply reported here with no assessment. Every clinician has a slightly different take, but here is a general example:

1<sup>st</sup> line – T, P, R, BCS, body weight, mucous membranes, CRT, hydration status

EENT – (eyes, ears, nose, throat)

PLNS – (peripheral lymph nodes)

H/L – (heart, lungs)

ABD – (abdomen, rectal exam findings)

UG – (urogenital, rectal exam – prostate or urethral palpation per rectum)

MS– (musculoskeletal)

Integ - integument

N – (basic neurologic exam – not a full exam, but general assessment of mentation, gait, cranial nerves)

Some parts of the SOAP are more thorough depending on the presenting complaint:

1) NEURO – (full neurologic exam – mentation, gait, cranial nerves, reflexes, etc.)

2) ORTHO – (this is not a separate section, it falls under the MSI section, but may be much more thorough with a complaint of lameness)

### *Example of a objective section from a normal physical exam:*

T 100.1 , P 80 , R pant; BW – 24.5 kg, BCS 5/9; m.m. pink, moist, CRT < 2sec, hydrated

*EENT* – no evidence of dental calculus, no nasal discharge, no other significant findings

*PLNS* – peripheral LNs are normal in size, and no firm or painful LNs were identified

*H/L* – normal sinus rhythm, no murmurs ausculted, pulses strong and synchronous; no evidence of increased respiratory rate or effort, bronchovesicular sounds are normal

*ABD* – soft, non-painful, no palpable organomegaly, masses, or other abnormalities; normal rectal exam with no palpable masses, and normal brown stool on exam glove

*UG* – moderate sized bladder; prostate is normal size, symmetric, and non-painful

*MSI* – no evidence of lameness, ideal BCS; nice hair coat, no abnormal findings

*NEURO* – normal gait and mentation, CNs normal; full neurologic exam not performed

If a patient is hospitalized, the OBJECTIVE section is also where you put any lab results, imaging results, or other diagnostic testing results after the exam findings.

EX:

CBC – Low PCV 20% (37-55), High MCV 82 fl (60-78), Low MCHC 30 g/dL (32-36), Low TP 5 g/dL (6-7.9), normal platelets 392,000, normal leukogram (WBC 12,000).

\*Note, that not every value is written down, but all abnormal, and any relevant normals are written (it is nice to know that when you think an animal may have blood loss, that the platelets are normal, details make it easier to form a helpful differential list that way).

A: assessment of your subjective and objective findings. Again, each clinician has a different take on the format of this, but when you are starting, the easiest thing is to list each problem (A1, A2, A3, etc.), and a list of rule-outs for each problem.

Ex: Ginger is a 4 y o S golden retriever who was presented today for a 3 day history of vomiting and diarrhea. Problems include:

A1 – acute vomiting – R/O primary GI (foreign body, dietary indiscretion/gastroenteritis, parasites, GI lymphoma, other) vs. secondary metabolic (pancreatitis, Addison's disease, acute renal failure, hepatitis, other)

A2 – small bowel diarrhea (large vs. small depends on your history taking and exam findings) – list of rule-outs

Your problem list is generated from historical findings (history of vomiting and small bowel diarrhea in above example even if you don't witness it), physical exam, and labwork, and yes, you should write out differentials for individual lab abnormalities (hypercalcemia, elevated ALT, low cholesterol, each individually at least initially).

P: plan! Now you take your problem list and you can do one of two things. You can address each problem with a corresponding plan (P1 for A1 and so on), but this leads to repeated writing of tests if they address two problems (i.e. a chemistry panel may be part of your plan vomiting and diarrhea, why write it twice?). A simpler way to do it is to write what you want to do and why. This section includes diagnostic and treatment plan.

EX:

*Diagnostics:*

Complete blood count - to assess for neutrophilia, bands toxic change suggestive of inflammation or infection

Chemistry profile – screen for metabolic causes of V/D and changes in proteins and electrolytes

Urinalysis – to assess renal tubular function

Fecal exam – to rule out parasites

Abdominal radiographs – to look for obstruction, abdominal masses, foreign objects

*Treatment:*

NPO – to rest the GI tract and decrease vomiting

Dolasetron – to treat vomiting

IV fluids – for rehydration

When you are writing the plan for hospitalized patients, include details! For instance, if you want to give fluids, you should write what type, what rate, and how you decided on that rate (calculate dehydration + maintenance + losses). If you plan to give a drug, say what it is, the dose and route and frequency, and why. Remember that the SOAP is dynamic for inpatients and that with each day: your S is compared to the last S, your O should focus on the changes in findings, the A should change as diagnoses are made, things resolve or new problems arise, and the P should change as the needs for the patient change. Do not write a SOAP that says, “no changes from yesterday, continue with plan from yesterday.” SOAPing inpatients is an exercise in developing your critical thinking about cases, and you’ll get out of it what you put into it. You will understand your case that much better if you put the time into your assessment each day.

INITIAL ASSESSMENT:

Day time appointments have a SOAP written on the physical exam sheet in the record, and in the discharge, but when patients enter the wards or CCU, they also need an initial assessment. This is really just a summary of the signalment, chief complaint, and history of the patient, followed by the initial SOAP. After this initial assessment, your daily record should include a SOAP only, no need to repeat this section.

EX:

SIGNALMENT AND CHIEF COMPLAINT:

Sam is a 4 year old neutered pug who was presented today for respiratory distress.

HISTORY:

Relevant history up to the presentation, and past medical history (summarized usually in a sentence or two, possibly more if the dog has several past problems) including drug history, travel history, or other facts relevant to the case.

PHYSICAL EXAM:

This is where your SOAP goes.

The beauty of the initial assessment is that you can type it up on a computer and print it up for the in-hospital record, but you can also copy it and paste it into your discharge report for the referral report. We are here to help you develop your SOAP writing, and you should expect us to evaluate your SOAPS. We will discuss the SOAPS with each appointment, but you should expect to receive comments from us on inpatient SOAPS as well. If you are not getting feedback, please let the clinicians know, sometimes we are forgetful, but you are putting the work in and deserve the feedback from us!