S. o. a. p. medical report

SOAP notes refer to a documented report, provided by your vet, that describes your pet’s medical history. What are SOAP Notes? SOAP notes are just another name for your pet’s medical record and are a must-have for pet insurance. Sometimes SOAP notes are casually referred to as a full “nose-to-tail exam.” Why SOAP? Good question! SOAP is an acronym for Subjective, Objective, Assessment, and Plan. This method of documentation is designed to be shared between different care providers (including your insurance company). SOAP notes are organized in a pretty universal way that makes it easy for new parties to understand a patient’s chart. They’re structured using a “SOAP format” that helps multiple care providers sync up on your pet’s health without having to consult with one another. This is why they’re the best document to provide when asked for your pet’s medical record. What kind of details will SOAP notes include? Here’s what you can expect your pet’s medical record to include: Notes on the condition of fur, skin, eyes, ears, mouth, joints, and other body systemsBlood test/fecal test resultsDetails on diet/exerciseDetails on current medicationsDate of last vaccinationAny medications they are being sent home with today The SOAP note format gives a full picture of your pet’s quality of care and medical history by breaking down any surgical history, diagnostic test results, physical exams, x-ray results, current medications, and objective data that will help your pet’s healthcare provider build the perfect treatment plan for whatever your pet is facing.This can help clinicians in their decision making, especially if there’s a history of present illness that can inform how to best care for your pet. Why might an insurance company ask for SOAP Notes? Insurance companies need to know your pet’s health care history in order to provide the best service possible, and since they don’t cover pre-existing conditions, your pet’s medical record will be vital to determining which conditions, if any, are considered pre-existing. A pre-existing condition refers to any kind of illness or health issue your pet developed before the start date of your pet health insurance policy and before your waiting periods have ended. It doesn’t mean your pet will be denied insurance coverage. It just means your plan won’t cover costs that directly relate to any ailment they were diagnosed with, had symptoms of, or were treated for before they had a Lemonade policy. Can my pet health insurance provider participate in a claim without my pet’s medical record? No. Some insurance companies might not let you know they need a copy of your medical record until you file a claim. But then you’ll find that, before they’re ready to participate in the cost of treatment, your insurer will want to check a medical record. At Lemonade, we require a medical record that includes info from a visit that took place within 12 months of your policy’s start date. You can also sign up for your Lemonade policy and then get your updated medical record together within 14 days… but don’t forget! It’s easier to have all your documentation in order as soon as possible. If you can’t provide a medical record from that time frame you might consider canceling your policy and getting a new one when you’re ready, since we wouldn’t be able to help with the cost of your medical payments without that record. How do I get a copy of my pet’s SOAP notes? If you’ve just taken in a pup or kitten, your tiny new friend likely doesn’t have a medical history yet. So while there may be no records to obtain, there’s also no better time to start a medical record! Take your pet to the vet for a medical exam to find out what the status of their health is, and start what we hope will become a long record of a healthy life. (BTW, the earlier you get insurance the more likely your pet is to be free of any pre-existing conditions. That means you’ll likely save more money on treatments and illnesses over your pet’s lifetime.) If you’ve adopted your pet from a shelter, they should hand over a copy of your new pet’s medical history that you can pass along to your new vet. If you adopted your pet from a friend or a private owner, just be sure to remind them that you’ll need whatever medical records they have. This will help to ensure your pet has already been–or will be–given all appropriate vaccinations and subsequent boosters, and checked for any health issues. What if my pet has had multiple vets? It’s not uncommon for your pet’s former veterinarian’s office to mail, email, or fax your pet’s medical history to a new vet. If you’re switching vets you can also request a copy for yourself and bring it along to your pet’s first appointment with their new doctor. Vets are legally required to release your pet’s records to you, so you shouldn’t have any problem obtaining a complete record. Mastering SOAP notes takes some work, but they’re an essential tool for documenting and communicating patient information. Ineffective communication is one of “the most common attributable causes of sentinel events,” according to an article in the Journal of Patient Safety. Given these stark consequences, the ability to convey medical information accurately, clearly and succinctly is a key skill all clinicians in training should strive to master. In modern clinical practice, doctors share medical information primarily via oral presentations and written progress notes, which include histories, physicals and SOAP notes. SOAP—or subjective, objective, assessment and plan—notes allow clinicians to document continuing patient encounters in a structured way. Exactly what is a SOAP note? Here’s an overview of how to write progress notes. Subjective 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. In a previous post, we reviewed the necessity of basic best practices for SOAP notes including legibility, identification, and dated chart entries. In this post, we review the proper structure and contents of a SOAP note. The acronym SOAP stands for Subjective, Objective, Assessment, and Plan. Each category is described below: S = Subjective or symptoms and reflects the history and interval history of the condition. The patient’s presenting complaints should be described in some detail in the notes of each and every office visit. Using the patient’s own words is best. Routine use of one-word entries or short phrases such as “better”, “same”, “worse”, “headache”, “back pain” is usually not sufficient. In follow-up notes, “S” is a reiteration of the chief complaints elicited during the initial evaluation of the patient. The complaints should reflect change over time. The patient’s responses to the previous treatment, resumption of daily or occupational activities, intervening injuries, and exacerbations are also noted in “S.” “S” should also describe improvement in the patient’s activities and physical capacities in the interim since the last treatment. Also included in this section are explanations for any hiatus in treatment and the patient’s compliance with recommended home care. O = Objective or observations. This section includes inspection (e.g., “patient still walks with antalgic gait”) as well as a more formalized reevaluations such ranges of motion, provocative tests, specialized tests (fixations, tongue, pulse, BP, labs). The extent of the reevaluation at each office visit is determined by the information gathered in “S” together with the original positive clinical findings as well as changes in “O” at previous office visits. Usually only the critical indictors need be repeated. Findings should be qualified and quantified in order to be able to ascertain progress/response to care over time. Indicators for treatment should always be identified in order to document necessity of the treatment provided and described in “Plan” section of the note, for example motion palpation findings, stagnation of blood and chi, or abnormal lab values. A = Assessment. Initially this is the diagnostic impression or working diagnosis and is based the “S” and “O” components of SOAP. On follow-up visits the “A” should reflect changes in “S” and “O” as a response to time, treatment, and other interim events (e.g., “Cervical strain, resolving” or “exacerbation of right sacroiliac pain”). “A” should be continually updated to be an accurate portrayal of the patient’s present condition. Other components of “A” may include the following where appropriate: patient risk factors or other health concerns, review of medications, laboratory or procedure results, and outside consultation reports. P = Plan or Procedure. The initial plan for treatment should be stated in “P” section of the patient’s first visit. A complete treatment plan includes treatment frequency, duration, procedures, expected outcomes and goals of treatment. An initial treatment plan may be for an initial trial of treatment over a short interval with a re-assessment and further treatment planning at that later time. On each follow-up visit, “P” should indicate modalities and procedures performed that day, continuation or changes in the overall treatment plan. “P” should also describe what the patient is to do between office visits, what the expected course of treatment is, what further tests might be ordered (e.g., “Obtain cervical MRI if upper extremity paresthesia persists”), and the disposition of the case (discharge, referral, etc.). It is also appropriate to include in this section any comments with respect to the patient’s compliance. Other items or events to be charted include: Any phone or personal contact with the patient. Missed appointments, rescheduled appointments, or when the patient is significantly late for an appointment. The receipt of important correspondence regarding the case. Requests for medical records sent or received. Transmittal of records, correspondence, etc. X-rays and other imaging studies, lab work, consultation reports.