

Principles

- If you don't write it down, it never happened: include everything relevant
- Speak in your own voice
- Avoid confusing medical abbreviations and acronyms
- Include all mandatory reporting fields *and times of interventions*, no matter which format you choose
- Be clear, concise, consistent, objective
- Avoid hearsay (as opposed to a family member providing medical history)
- Proofread

Example of a SOAP Note for EMS: Darling Soapie-a

	<p>DARLING notation: Dispatch And Response Location Including Nature Given</p>	<p><i>¶ Dispatched to the Sharpe Refectory for a person possibly in respiratory distress. Responded priority; ALS not available.</i></p>
<p>S</p>	<p>SUBJECTIVE</p> <ul style="list-style-type: none"> ● These are subjective findings that you learn from the patient and/or bystanders ● May include direct patient quotes. ● Include chief complaint described by patient. ● Include pertinent past medical history determined from your history taking. ● Include symptoms described by patient and determined from your history taking. ● Include pertinent negatives determined from your history taking 	<p><i>¶ Patient states "I can't swallow." Bystanders report that patient was eating lunch of unknown ingredients when he started to cough and panic. Friend says patient has history of severe asthma and multiple food allergies and has required intubation in prior situations. Carries an EpiPen but has not taken it today. Patient indicates that he feels difficulty when coached to take a breath and swallow but denies pain or nausea. Is not sure what he ingested.</i></p>

O	OBJECTIVE <ul style="list-style-type: none"> • These are objective findings that you determine by observing and examining the patient. • Includes level of consciousness, general appearance/presentation, all assessment findings including vitals and physical exam. 	<i>¶ Patient is alert and oriented but clearly in distress. Audible stridor and tripodding; breath sounds on auscultation wheezing all fields. Skin is flushed, warm, and slightly diaphoretic; notable facial edema and hives on neck, trunk, and upper extremities. SpO2 is 92% on room air; HR 120, BP 100/70.</i>
A	ASSESSMENT <ul style="list-style-type: none"> • This is a brief summary of your findings; it is your differential evaluation of the problem. 	<i>¶ 21 year old male experiencing anaphylactic reaction to unknown allergen.</i>
P/ I	PLAN/INTERVENTIONS <ul style="list-style-type: none"> • This is a record of the care and treatments performed by EMS. 	<i>¶ Administered O2 via NRB/15lpm and 0.3mg epi 1:1000 IM in R deltoid. Transferred patient to stretcher, semi-Fowlers and fully secured, covered with a blanket and moved to ambulance. Transport initiated BLS.</i>
E	EVALUATION <ul style="list-style-type: none"> • This is your re-assessment of the patient after treatment: note any trends or changes 	<i>¶ Pt lung sounds still wheezes all fields and SpO2 94% on O2. BP 110/70, HR 120. Administered second round of epi with some improvement. Facial edema subsiding and patient reports some relief, can stick out tongue and swallow with less difficulty. Third set of vitals unchanged as noted.</i>
A	ARRIVAL <ul style="list-style-type: none"> • This is your record of patient transport, transfer or care, and any pertinent information such as belongings left with patient. 	<i>¶ Transport for patient with one friend was priority to Miriam Hospital where care was transferred to RN with report. Patient belongings and cab voucher left in custody of friend, with instructions.</i>