Writing SOAP Notes

In general, take notes on the info others are collecting. You will incorporate the data into your SOAP note. A few pointers:

1. Pharmacy notes for this clinic are a supplement to the practitioner's note so they don't reiterate everything. The notes should be med focused but contain enough subjective/objective info to tell a story around the problem. Meds are always subjective data.
2. Be sure that when you get to the assessment and plan, there shouldn't be any newly introduced information
3. Your assessment should be -- what the patient likely has, the severity (despite appropriate therapy or in the absence of medication etc), etiology of the problem, what needs to be done to address it
4. Plan should have specific information on new starts, things to stop or continue. Also, include any counseling/patient education provided to the family during the visit. If including anything like 'Patient needs to have further labs' try to be specific and assign ownership eg. Patient will obtain labs from LabCorps and results will be forwarded to GI team for the follow-up appointment.
5. Our notes will not be seen by the patient, unlike what happens in some clinics. They are a provide-to-provider communication and as such should use appropriate medical terminology except for detailing patient education. For that part, we want to describe exactly what was told to the family so that other providers have an expectation of what the patient should know about the meds and conditions.