Sample - Pharmacist's SOAP Note

The pharmacy care plan is a useful and required documentation tool for pharmacists, as it facilitates continuity of care for patient. However, it is not always necessary to communicate all the information presented in the pharmacy care to other health care providers. The pharmacist must use his or her discretion to decide what information should be communicated. A SOAP note is one documentation format that is commonly used for documenting in-patient charts, in the institutional setting. It uses the problem-oriented approach to documentation, where S = Subjective information, O = Objective patient information, A = Assessment of the problem (i.e., your Thought Process) and P = plan of how the problem will be addressed and when follow-up will occur. For more information on subjective and objective data, please refer to the Appendices. Consider the SOAP note as an abbreviated version of the pharmacy care plan, where only the pertinent information from the pharmacy care plan is provided. If you recall, in the pharmacy care plan, all the "subjective, objective and assessment" were summarized together under *assessment*, and the Plan was summarized under the *Therapeutic Plan/Pharmacist's Recommendation*. The following provides an example of a SOAP note using Patient Walsh as an example.

S:
Mrs. Walsh has been concerned about developing osteoporosis since many of her friends have been diagnosed with osteoporosis. She is eight years postmenopausal, has never taken calcium supplements and her diet provides her with negligible amount of elemental calcium. She does not like to take milk products, although she does take a multiple vitamin that provides her with vitamin D 400IU. She does not have a family history of osteoporosis and has an active lifestyle, which consists of gardening and golfing in the summer, and two miles every day in the winter. She mentioned that she has never discussed osteoporosis with her physician, has never had a bone density done and has never been on hormone replacement therapy.

O:
She is a 65 years old Caucasian female of small build. She is not on any medications that can increase her risk of osteoporosis.

A:
Mrs. Walsh's calcium intake is significantly lower than what is suggested by the guidelines for prevention of osteoporosis (1.5g per day). This puts her at an increased risk of developing osteoporosis, and she would benefit from additional calcium supplementation.

P:
1. Calcium carbonate 600mg twice daily (breakfast & supper)
2. Provide a sheet summarizing calcium content of various foods. If Mrs. Walsh diet should change to include these food groups, her dose of calcium should be adjusted.
3. Provide a pamphlet discussing osteoporosis
4. Have Mrs. Walsh make an appointment for tomorrow to: 1) discuss osteoporosis and, if necessary, refer her to her physician for further evaluation, and 2) discuss her falls and Valium use
5. Recommend that she continue with her exercise program.

F/U: Have patient call pharmacist in two weeks to reevaluate the plan based on the monitoring parameters discussed.