

**DOCUMENT MEDICAL CARE: SOAP NOTE FORMAT**

For use of this form see TC 8-800; the proponent agency is TRADOC.

**TABLES:** IV

**REFERENCES:** STP 8-68W13-SM-TG, Task: 081-833-0145, Document Patient Care Using Subjective, Objective, Assessment, Plan (SOAP) Note Format; Textbook of Basic Nursing.

**1. Soldier** (*Last Name, First Name, MI*)

**2. Date** (YYYYMMDD)

**CONDITIONS:** Given a patient relating signs and symptoms of an illness or injury in a clinical environment or field setting. You are not in a CBRN environment.  
One of the critical skills that a Soldier Medic must understand and master is the accurate documentation of symptoms and observations made during patient assessment and management. Entries written in a patient's medical record are legal and permanent documentation of what the patient tells you, what you observe about the patient, your assessment of the patient's problem, and your plan for managing the patient. Remember, "If you didn't document it, you didn't do it."

**STANDARDS:** Perform all measures IAW Textbook of Basic Nursing. You must score at least 70% (*5 of 6 steps*) and not miss any critical (\*) elements on the skill sheet.

**SAFETY:**

- o Risk Assessment: Low.
- o Environmental: None

**NOTE:** Soldier Medics must be observed. (*Evaluator to Soldier Medic ratio is 1:6*).

**TEST SCENARIO:**

While working at the forward operating base aid station, you encounter a conscious 66 year old male contractor relating a chief complaint of difficulty in breathing and chest pain. He says he fell down a flight of steps and his chest hurts. His airway is open and he is too short of breath to speak in full sentences. His respirations are 22, rapid and shallow. He has a radial pulse of 130 and his blood pressure is 90 over 60. There are bruises on his rib cage. Using the SOAP Note format, record the appropriate information.

**3. Evaluator's Comments and After-Test Recommendations:**

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**DOCUMENT MEDICAL CARE: SOAP NOTE FORMAT  
GRADING SHEET**

TASK	COMPLETED					
4.	1ST		2ND		3RD	
	P	F	P	F	P	F
a. * Recorded the patient's name, rank, date, and time.	<input type="checkbox"/>					
b. * Wrote the subjective <b>(S)</b> data as related by the patient. <i>(Included history applicable to the chief complaint.)</i>	<input type="checkbox"/>					
c. * Wrote the objective <b>(O)</b> data. <i>(Included a physical examination relevant to the chief complaint.)</i> <b>EVALUATOR: The objective data block should not contain any subjective or historical information.</b>	<input type="checkbox"/>					
d. Wrote assessment <b>(A)</b> data.	<input type="checkbox"/>					
e. Wrote the plan <b>(P)</b> .	<input type="checkbox"/>					
f. * Finished the entry with signature, printed name, rank, and title.	<input type="checkbox"/>					

\* Critical Elements



**DOCUMENT MEDICAL CARE: SOAP NOTE FORMAT  
EVALUATOR GUIDELINES AND INSTRUCTIONS**

**EVALUATOR GUIDELINES AND INSTRUCTIONS:**

- o Inform the Soldier Medic of the CONDITIONS and STANDARDS as stated on this form.
- o Provide an optional scenario, if appropriate. This scenario should reinforce the unique or particular needs of the unit.
- o Allow sufficient time for the Soldier Medic to extract information from the scenario.
- o Provide each evaluator with the grading sheet.
- o Ensure the Soldier Medic has all required materials.
- o Explain how the exercise is graded.

**Resource Requirements:**

**Evaluator:** Grading sheet and applicable scenario.

**Soldier Medic:** Applicable scenario

**Additional Scoring Guidelines:**

Write the subjective (**S**) data as related by the patient.

- o Age, sex and race of the patient.
- o Chief complaint.
- o History of present illness/injury (*HPI*)- using OPQRST-A.
  - O**nset
  - P**rovoking/Palliative factors
  - Q**uality
  - R**adiation
  - S**everity (*scale of 1 - 10*)
  - T**iming
  - A**ssociated symptoms
- o Written in the patient's own words (*with quotation marks as needed*)
- o Past history - using SAMPLE.
  - S**igns/symptoms (*already covered by HPI*)
  - A**llergies
  - M**edications
  - P**ast History
    - Past Medical History (*PMH*)
    - Past Surgical History (*PSH*)
    - Social History (*soc Hx*)
  - L**ast oral intake
  - E**vents leading to illness/injury (*usually same as Onset*)

Write the objective (**O**) data.

- o Observations made that relate to the subjective data, to include sight, sound, touch, and smell.
- o General impression.
- o Vital signs.
- o Pertinent physical examination findings by body area.

Write assessment (**A**) data. Recorded interpretation of the patient's problem/condition as well as conclusions based on an analysis of the subjective/objective data.

Write the plan (**P**)

- o Listed course of action to resolve the problem.
  - Profile/limitation in duty the patient can perform.
  - Medication (*s*) dispensed.
  - Patient education.
- o Numbered the plan.