SOAP Notes

SOAP Method

A common method of documentation employed by many healthcare providers is using the SOAP note, which is an acronym for subjective, objective, assessment, and plan. Let us review the four components of a SOAP note:

Subjective – A brief statement of the patient's purpose for the office visit or a description of symptoms quoted in the patient's own words. This is also known as the chief complaint.

Objective – Unbiased observations by the doctor or dental team members that include the patient's vital signs (blood pressure, pulse, respiration) and any results of examinations (e.g., perio readings, what is seen on any radiographs taken, etc.). Basically, the facts that can be seen, heard, felt, measured, touched, and smelled.

Assessment – Diagnosis by the doctor of the patient's condition.

Plan – Proposed treatment plan addressing the patient's problem(s). Be specific. For example, "caries" is too general a diagnosis. Instead, each separate tooth (as well as each surface on each tooth) that is carious should be listed. This should also include the discussion with the patient regarding his condition and his decision regarding treatment (i.e., when the patient plans to proceed with treatment, if the patient has been referred to another provider for treatment, or if the patient has declined treatment).

Informed Consent

Informed consent must be obtained from the patient prior to providing treatment. Informed consent means that the patient was fully informed of the treatment to be performed (both pros and cons) and was allowed to ask questions, and that the patient is of legal age and of sound mind. Patients may provide informed consent verbally (implied) or in writing. In the case of a law suit, implied consent is much less reliable, making written consent preferable. Patients also have the right to refuse treatment in which case the provider should obtain a signed informed refusal from the patient.

The PARQ system is widely used in dentistry to ensure proper treatment plan discussions with the patient. This formula is extremely helpful:

Procedure – Describe recommended procedures/treatment plan to patient.

Alternatives – Describe any alternatives to the recommended treatment (including refusal of treatment). Also explain the possible outcome if treatment is rendered.

Risks – Explain any risks that may be involved with proceeding with treatment, as well as the risks of declining treatment.

Questions – Allow the patient to ask any questions and answer all questions to his satisfaction.

SOAP Notes

SOAP/PARQ Example

Date: 11/9/2014

S ⇨ Patient indicated, "My top gum is swollen" and points to #3 and says, "My mouth tastes bad, and it bleeds when I brush in that area."

O ⇨ Reviewed health hx: perio readings #3 WNL (within normal limits) except MF is 6mm and ML is 5mm, bleeding and exudate on probing; requested PA and BW of #3 due to clinical evidence of pathology; PA & BW show approx 3mm bone loss on mesial, no caries, no PA lucency.

A ⇨ Periodontal abscess.

P and PARQ ⇨ Procedure explained; alternatives explained – tx by curetting the pocket or do not treat, pt chose treatment; risks explained, all pt questions were answered; 2% xylo w/ 1/100,000 epi 1.8 ml; curetted mesial #3; gave post-op instructions – warm saline rinse q4h, while awake, for 24 hr, OHI given; next visit: comp perio eval; JArnold, DMD assisted by JDimmery.

Amending Chart Notes

Never alter or add to original chart notes once they have been documented. However, chart notes may be amended if the note is in error or if something was omitted. In this case, be sure to date and sign the amended chart note(s).

Amended Chart Note Example:

Date: 11/9/2014

S ⇨ Patient indicates, "My tooth is sensitive to sweets" and points to #2.

O ⇨ Pt new to practice, came in on emergency basis; rev. health hx; visual exam shows #2 occlusal caries, requested BW due to carious lesion, BW shows #2 mesial caries; perio readings WNL on #2.

A ⇨ Mesial occlusal caries on #3.

P and PARQ ⇨ Recommended MO restoration; alternatives of gold inlay, ceramic inlay, MO amalgam, MO composite and tx explained, pt chose MO amal, risks explained of each alternative, pt questions answered; 2% xylo w/ 1/100,000 epi 1.8 ml; removed caries, placed MO amalgam. Told patient to follow soft diet for 24 hours and to call if sensitivity persists. Next visit: comp oral eval and FMX JArnold, DMD assisted by JDimmery.

11-9-2014 Error in transcription. Assessment: on 11-9-14 note should have indicated mesial occlusal caries on #2 JArnold, DMD.

Some practices using paper charts will draw a line through the incorrect part of a chart note, correct the note and initial the change. This method is not recommended since all parts of the chart must remain legible. This process may make the entry too difficult to read (not only the initial error but also the correction). Rather, simply create a new chart entry, as outlined above, to correct any chart error notes.