SOAP ORGANIZATION & REPORTING

SUBJECTIVE:

1. Primary complaint: CC, or Pt C/O
2. Rescue circumstances
3. Background of problem (Hx of present illness/accident)
4. Patient age
5. Previous medical Hx
6. Current medications
7. Allergies
8. Pertinent negatives

   NOTE: Information may come from bystanders, family/friends or health care professionals, etc. Document who information was obtained from. If unable to obtain any pertinent info, document reason for NOT getting facts.

OBJECTIVE:

Patient Age, Race, and Sex: (example: 35yoWM)

1. Position & location where patient is found.
2. Patient general condition (AVPU & Orientation): AAOX3, or CA0X3
3. VS (times must be included)
4. Skin color and condition
5. HEAD:
   a. Lacerations, confusions, abrasions, avulsions, ecchymosed, battle's sign, raccoon eyes.
   b. Equality and reactivity of pupils; PERL
   c. Blood/CSF from ears, nose and/or mouth
   d. Gross bone deformity
6. NECK:
   a. JVD, tracheal deviation, external trauma, sub-Q emphysema
   b. Deformities, tenderness, crepitus, ecchymosis of C-spine
7. CHEST:
   a. Symmetrical expansion, external trauma, deformities, crepitus, ecchymosis, sub-Q emphysema.
   b. BBS: equality and quality (decreased, wheezing, rhonchi, rales, or clear)
8. ABDOMEN
   a. Soft tissue injuries and/or penetrating injuries.
   b. Inspect for distension and palpate for rigidity or tenderness. Note any pulsating masses. NOTE: which quadrant evokes your findings?
9. PELVIS
   a. Tenderness On palpation and stability.
10. LOWER AND UPPER EXTREMITIES
    a. Inspect and palpate for external signs of trauma.
    b. Note any deformation and/or rotations and/or lengthening or shortening.
11. BACK
    a. Inspect and palpate for external signs of trauma, deformities, ecchymosis, swelling and tenderness. NOTE: if this is a trauma patient, you must document how you moved the patient to access his back (i.e., log rolled, as a unit, etc.)

SPECIAL PERTINENT INFORMATION:

Auto accidents must also have documentation as follow:

1. Seatbelt on/off at impact
2. Airbag deployed
3. Patient location in vehicle at time of impact and on your arrival.
4. Steering wheel, windshield and dashboard intact or deformed.
5. Where is vehicle damaged, and damage severity.
6. Insult to passages compartment.
7. Speed at time of impact.

ASSESSMENT:

What is your suspected conclusion of your findings?
What is the problems(s) you will treat patient for?
NOTE: If a Fx is open with bone exposed, you can make a direct statement. Example: An-open Fx of right humerus. This also supplies to soft tissue injuries or other obvious injuries that do not require x-rays of more definitive Dx.

PLAN:

This section includes all Tx and any +/- changes in the patient status.

1. On scene Tx.
2. Part of your Tx includes Physical Exam & VS.
3. Remember when listing meds given to state dosage in proper units (g. mg, mcg, 1 pm for 02, etc.) Also give the route of administration correctly (IVP, IV drip, SI, SQ, IM, etc.).
4. Basic and advance Tx must both be listed.
5. You must document what hospital was contracted, how they were contacted (telemetry, phone, radio, etc.) and were orders given? If there was no contact, state why.
6. Document if the patient was transported with/without incident.

ABDOMINAL PAIN

SUBJECTIVE:

1. Where did the Pain start? Where does it RADIATE to?
2. Describe the QUALITY (sharp, dull, cramping, burning, heavy, stabbing.)
3. Describe SEVERITY (on a 1-10 scale, 10 being worst).
4. Has Pt taken any Rx to relieve the pain, if so what and did it help?
5. Any recent injury to the abdomen (within the past two weeks?)
6. Nausea? Vomiting? If so, how many time? What color was emesis (green blood, coffee grounds)
7. When did the pain start? Activity at time of ONSET?
8. Is Pt. C/O fever?
9. FEMALE: LMP (last menstrual period, what was 1st day of last period)? Was there spotting, unusual odor, discharge?
10. If vaginal bleeding, how many pads were soaked daily?

LOWER ABDOMINAL PAIN

SUBJECTIVE:

11. Dysuria (painful, burning or difficult urination?
12. Frequency? Hematuria?
13. Urinary retention?
14. Last bowel movement? (black or tarry stools)?
15. Diarrhea: loose or watery and number of episodes?
16. Has Pt. Ever had history of this pain before/what did Dr. say problem was?
17. Any: SOB dizziness?

OBJECTIVE:

1. Expose abdomen and lie Pt. Flat.
2. Look for distention, obesity, flat, symmetry, old incision/wounds. (OLD INCISIONS OR WOUNDS require questioning Pt with info gathered in subjective.)
3. INSPECTION: Inspect abdomen, flanks, back for signs of trauma (Hematoma, ecchymosis, abrasions, puncture wounds, foreign bodies).
4. AUSCULTATION: Briefly for (bowel sounds present) RLQ is the area of greatest activity for BSP.
5. PALPATE: GENTLY. Always palpate area of pain last.
6. Soft or rigid?
7. Pulsating mass? If so, -DO NOT PALPATES THAT AREA ANY FURTHER.
8. Conjunctiva pallor? Color of sclera?

CHEST PAIN

SUBJECTIVE:

1. Where is the PAIN located; where does it RADIATE to?
2. When did the paid start? Time?
3. What was the Pt. Doing when pain started? ONSET?
4. Is it constant or intermittent?
5. Describe QUALITY (sharp, dull, burning, pressure, stabbing, crushing, etc.) GIVE CHOICES TO DESCRIBE QUALITY.
6. What did Pt. Take to alleviate the pain? (nitro? If an, how many and in what period of time. Mylanta? Etc.)
7. Was there any alleviation of the symptoms?
8. What is the SEVERITY (on a 1-10 scale, 10 being the worst?)
9. Is pain changed by breathing or movement? (If pain increased or decreased by inspiration, palpation or movement).
10. Any associated symptoms: SOB, nausea/vomiting, sweating, weakness, syncope, palpitations. When did this occur?
    NOTE: IF PT. DENIES ANY OF THE ABOVE SYMPTOMS, THEY WOULD BE CONSIDERED PERTINENT NEGATIVES.
11. Any recent chest trauma?

OBJECTIVE:

1. INSPECTION: Symmetrical chest rise.
2. Old incisions/wounds: (old incisions/would require questioning the Pt, with information gathered being placed in SUBJECTIVE).
3. note any medication topically applied. (nitro-patch).
4. JVD (with Pt. Sitting at a 45 degree angle).
5. EKG rhythm.
6. Skin color.
7. AUSCULTATION: Lung sounds bilaterally in all fields.
8. PALPATION: Chest wall for deformity, pain, crepitus.
9. PERIPHERAL EDEMA (1+-4+)
10. Capillary refill in seconds?
11. Check pedal pulses bilaterally and note strength (0=not present; 1+=weak, 2+=normal, 3+=bounding)

INFANT

SUBJECTIVE

1. Identify caretaker relationship with Pt. And their chief complaint with Pt.
2. Have them describe the Pt. Recent activity: (responds approximately, listless, sleepy, crying unexplainably)?
3. Voiding? How many times a day?
4. Taking fluids and/or food? How many times a day?
5. Tugging at care?
6. Has crying been consolable?
7. Has there been change of color, consistency or frequency of stool?
8. On schedule for immunizations? Have any been given recently?
9. Cough? (productive or unproductive?)
10. Frequency of medications taken and when last given?
11. Frequent eructation and or flatulence?
12. Is approximate weight know by caregiver?
13. If appropriate to complaint, ask of any recent known injury to infant.

OBJECTIVE:

1. Record pediatric OCS (eyes, cerebral, motor).
2. Do eyes track?
3. OBSERVE: For nasal flaring, tracheal tugging, increased respiratory effort, respiratory retractions.
4. OBSERVE: State of fontanels: Open? Closed? Sunken? Bulging? Flat?
5. Mucous membranes moist? Dry?
6. Consistency and color of stool?
7. Is diaper wet?
8. When last changed?
9. Drainage and color from nose?
10. Pulse oximetry reading?
11. Note emesis and its color.
12. Assess abdomen.

MOTOR VEHICLE ACCIDENTS

SUBJECTIVE:

1. Where does Pt. state his location was in vehicle at time of accident?
2. Wearing seatbelt?
3. Was Pt. ambulatory prior to EMS arrival?
4. LOC (per Pt. or witness)?
5. Head, neck, back pain (ask all Pt.).
6. Dizziness, dyspnea, nausea and vomiting?
7. Numbness and tingling to extremities?
8. Does Pt. know speed of his vehicle or of other vehicle at time of impact?
9. Admit to ETOH or drug use?
10. Any prior complaints by Pt. prior to MVA?

OBJECTIVE:

1. Where did you find Pt.?
2. Describe the mechanism of injury: location of the damage to the vehicle, drivers or patients?
3. Was there compromise to he Pt. compartment?
4. Was the steering wheel intact?
5. Was the windshield broken (externally or by Pt.)? Did the airbag deploy?
6. Address and describe all the areas that Pt. complains of in the SUBJECTIVE.
7. TRAUMA SCORE.

WEAKNESS

SUBJECTIVE:

1. ONSET of weakness?
2. Generalized or localized? (if localized, do neurological assessment).
3. Complaining of pain anywhere? (received any recent injury?)
4. Recent Fever?
5. Complaining of SOB?
6. Cough (productive or unproductive?)
7. Palpitations?
8. Syncope?
9. Any new meds taken?
10. Orthostatic dizziness or lightheadedness:
11. Color of stool? (specific questions for black and tarry stool).
12. Diarrhea or constipated?
13. Nausea and vomiting?
14. Dysuria?
15. FEMALE: Any vaginal bleeding that is unusual?

OBJECTIVE:

1. Conjunctive pallor?
2. Orthostatic vital signs probably will be indicated. CONSIDER
3. AUSCULTATE: bilateral breath sounds.
4. Obtain EKG and interpret.
5. Report INSPECTION and PALPATION of the abdomen.

NEUROLOGICAL

SUBJECTIVE

1. Dizziness? If so, syncope? If so, (SUSPECT C-SPINE INJURY, MAINTAIN FULL SPINAL, IMMOBILIZATION) Question a to head, neck or back pain,
2. If TRAUMA: Along with above: Any numbness or tingling to extremities?
3. Admit to ETOH or drug use:
4. Consider questioning these areas if relevant to Pt. complaint:
    - A) Headache?
    - B) Nausea and vomiting?
    - C) Photophobia?
    - D) Visual difficulty?
    - E) Pain, Quality, Radiation, Severity, Time?
    - F) Fever?
    - G) Seizure? (Have witness fully describe what was seen, did Pt. strike head)
    - H) When were seizure medication 1st taken?
    - I) Is Pt. reliable taking medication?

OBJECTIVE:

1. Conscious, alert, and oriented? (CAOX3) to Person, Place and Time: IF NOT ALL 3, SPECIFY WHAT PT, IS AND ISN'T ORIENTED TO.
2. Speech Quality: clear? slurred? garbled?
3. GCS: Specify total to each area if score is not 15.
4. Affect (mood or feeling tone). Flat? Inappropriate (how so)? Depressed? Restlessness?
5. PERRL: mm size, equality, reactivity (brisk or sluggish).
6. Facial symmetry?
7. Tongue midline?
8. Shoulder shrug equal & how strong?
9. MOTOR TESTING: Grip strength; equal? Strong or weak?
10. Arm drift? (test with eyes closed and fingers pointing out for 30 seconds).
11. Leg strength? (Pt. lifts leg against resistance with or without difficulty?
12. MAEX4: Moves all extremities times four with or without difficulty?
13. If fall, syncope or seizure: ALWAYS ASSUME C-SPINE INJURY & MAINTAIN FULL SPINAL IMMOBILIZATION. (question if head, neck or back pain).
14. If seizure, report exam or oropharnyx.
15. Check for incontinence of urine or stool.

RESPIRATORY

SUBJECTIVE

1. How long has the Pt. been short of breath? ONSET: (If chronic, when did it get worse?)
2. Any fall or injury?
3. Cough? (productive or non-productive). If so, what color was the sputum?
4. Any chest pain? If so, SEE CHEST PAIN GUIDE.
5. Frequency of respiratory medication, if any?
6. Any dyspnea on exertion? (DOE)
7. Orthopnea?
8. Dizziness?
9. Nausea and vomiting?
10. Fever?
11. If associated with weakness; any black or tarry stool?
12. Any numbness or tingling to extremities?

OBJECTIVE:

1. INSPECTION: Skin condition, temp, color?
2. Position Found?
3. Trachea midline?
4. Accessory muscle use?
5. Breathing pattern?
6. Does Pt. speak with or without accompanied dyspnea?
7. AUSCULTATION: Bilateral breath sounds for crackles (rales), wheeze (inspiratory/expiratory or both), stridor & fields sounds were heard.
8. PALPATION: Is there chest symmetry?
9. Palpate for subcutaneous air.
10. JVD? (With Pt. sitting at a 45 degree angle)
11. Peripheral edema (1+-4+)